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ABSTRACT

Intended to provide new caseworkers with an introduction to child abuse and neglect, the two part document presents information from a multidisciplinary perspective. Twenty-three articles in the first book and seven in the second are included on the social worker's role, assessment and counseling of abusive and neglecting parents, the impact of abuse and neglect on the child, community involvement, and the interview. Articles have the following titles and authors: "Historical and Charaterological Aspects of Child Abuse and Neglect" (E. Sherman): "Helping People Who Cannot Manage Their Own Lives" (I. Kaufman): "The Abused Parent of the Abused Child" (S. Wasserman): "Working with the Parent in Child Abuse Cases" (S. Holmes): "World of Abnormal Rearing Cycle" (R. Helfer): "Parents Who Hate" (L. Young): "The Concept of Authority and Its Use in Child Protective Service" (S. Yelaja): "The Use of Self" (M. Didier): "Dysfunctions of Parenting: The Battered Child, The Neglected Child, The Exploited Child" (R. Galdston); "The Abused Child" (S. Zalba): "Prevalent Types of Neglectful Mothers" (N. Polansky); "Training Program in Child Abuse and Neglect--Needs of Children Summary" (J. Ives): "Children's Play Characteristic of Different Ages" (A. Gesell): "Composite Developmental Inventory for Infants and Young Children" (American Medical Association): "When to Suspect Child Abuse" (V. Fontana): "The Enmeshment-Disengagement Cycle" (S. Minuchin); "Creaming the Poor" (S. Miller); "Concepts of Community: Is It a Where, a When, or a How" (A. Panzetta); "Community Organization in the Direct Service Agency" (V. Sieder); "Community Resources and Protective Service Work in Child Welfare" (S. Pflanczer); "Parent Rehabilitation and Enrichment Program" (B. Ambrose): "Away with the 'Bedside Manner'!" (S. Jourard): and "Interviewing Techniques in Probation and Parole" (E. Hartman). The second volume presents seven articles: "Applications of Transactional Analysis to the Problems of Child Abuse and Neglect" (E. Sherman, Jr.); "Treatment of Abusive and Neglectful Families" (S. Wells): "Incest: A Beginning Look at Assessment and Treatment" (J. Kilroy); "What Separation Means to a Foster Child" (M. Didier): "What the Separation Process Means to the Foster Care Worker: (M. Didier); "Caseload Management in Local Departments of Social Services" (S. Pflanczer); and "Roles, Patterns, and Process in Supervision" (M. Didier). (CL)

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CHILD ABUSE AND NEGLECT

Social Services Reader I

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State University of New York at Albany

Second Edition, 1977

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OBJECTIVE

The purpose of the *Social Services Reader I* is to provide new caseworkers with a beginning acquaintance with the many facets of knowledge, attitude and skills necessary in working with abusive and neglectful families.

This reader presents a multidimensional approach of the various professionals — social workers, doctors, lawyers, psychologists and psychiatrists involved in the field.

It is not intended to cover all aspects or viewpoints, but to reflect the basic approach presented in the First Child Abuse and Neglect Training Program.

ACKNOWLEDGMENTS

I would like to thank the following individuals for their contributions and assistance in assembling this reader: Dean Charles T. O'Reilly, Ph.D., School of Social Welfare and all of the authors who allowed their articles to be reprinted.

Thanks are also due to Barbara D. Engel and Eloisa L. Ernst for their editorial and secretarial assistance in the revision and preparation of this manual and to the graduate students from the School of Social Welfare who helped research, summarize, and reproduce many of the articles.

Bernadette M. Ambrose, ACSW
Editor

INTRODUCTION

The following articles* will introduce you to ideas, theories, and practice applications in Child Protection work, so that you can work better with abusive and neglectful families.

Many complex configurations of personality lead to abuse, and no specific theory identifies them all, but you may examine clusters of behavior that lead to abuse or neglect. Sherman (1) provides a cross-cultural, historical perspective of the treatment of children by parents, and the common characteristics and dynamic make-up of abusive parents. As Kaufman (2) points out, traditional middle-class psychiatric approaches usually fail with these clients because they are not motivated to seek help; they are basically mistrustful; they are unable to discuss their feelings; and they are isolated, inconsistent, and lacking in self-esteem.

The primary medium of casework is talking — verbally expressing needs, wants, and desires; and seeking problem-solving means to meet them. Generally, caseworkers, used to dealing with motivated, consistent individuals who are able to ask for and use help, must expand their vision to look at non-verbal behavior as a means of client self-expression, since verbal skill is often wanting.

Wasserman (3) and Holmes (4) observe that the cycle of abuse is learned and that the abused child frequently becomes the abusive parent. Young (6) notes that severe abuse may be a pervasive fascination with punishment itself. In each case, the abuse/neglect is only the surface of a deep individual and family problem. In his "World of Abnormal Rearing Cycle", Helfer (5) notes that the client, because of negative feelings and low self-esteem, resents the intrusion of an outside worker and projects his rage upon him.

From the beginning, you, the worker, while maintaining your own equilibrium, must assess the person-problem situation by looking at the client's specific behavior and evaluating the amount of stress involved. Despite their problems, most abusive parents have a genuine relationship with their children and do an adequate job of parenting; yet you must help them control their abusive behavior in order to achieve a healthier interaction with their children. You must be at once honest and straightforward about why you are there: not to focus directly on the abuse, but rather to deal indirectly with the circumstances surrounding the abuse. You show acceptance and concern, using the dependency already there, to build a positive relationship, to involve the parents in rehabilitation and enrichment; then the parents may learn to communicate with each other and with you, to gain a more enhanced self-esteem, and to develop more rational expectations in child development. Thus, by providing a positive role model, by restituting the nurturance of parenting, and by meeting needs, you have broken down the wall of isolation and arrested the cycle of abuse/neglect.

Sometimes your dual role of helper and agent of the community is confusing and even paradoxical. Yelaja (7) explains this duality at length, as seen by both the client and the worker, noting the inherent qualities of authority and the benign use of authority as most beneficial. Didier (8) examines how the worker can use the self professionally.

Galston's "Dysfunctions of Parenting" (9) defines by behavioral effect the traits of the battered, neglected, and exploited child. Zalba (10) and Polansky (11) offer help in assessing and counseling abusive and neglectful parents. Ives (12) summarizes the effects of deprivation on children as seen in the tasks of childhood, focusing on the child-family-society relationship.

Short, specific inventories of children's characteristics at various developmental levels appear in Gesell's article (13) and the AMA Developmental Inventory (14). Minuchin examines the cycle of enmeshment-disengagement of the disorganized and disadvantaged family (16).

Child Protection will necessarily involve you with all parts of the community. As noted by Miller, et al. (17), Panzetta (18), and Sieder (19), the worker must know what is available to serve the client, formally and informally. You must strive to meet unmet needs by using existing agency facilities or by creating new ones. Creaming the poor, a common practice among Child Abuse and Neglect clients and one of the primary reasons for their isolation, has a devastating cyclic toll and you have to deal with it positively.

Pflanczer's "Community Resources and Protective Service Work in Child Welfare" (20) provides a system that is operational in most local departments of Social Services; it describes the specific needs of the caseworker relative to community resources. A concrete example of interagency cooperation in establishing and working with an ongoing group-treatment resource for ADC parents in need of the Child Protection Service's outreach treatment appears in the Ambrose paper (21).

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Closely related to Child Protection work and the frequent contacts you will have are the legal and medical questions about abuse. Vincent Fontana's "When to Suspect Child Abuse" (15) provides the medical criteria for determining whether or not a child has been abused; Jourard's "Away with the 'Bedside Manner'!" (22) shows how to conduct an interview in any situation, by being open and available to your clients; and "Interviewing Techniques in Probation and Parole" by Hartman (23) will help you establish a client-worker relationship.

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Child Abuse and Neglect: An Overview

An introduction to child abuse and neglect and to the theories underlying modern treatment approaches from the historical and psycho-social perspectives

Historical and Characterlogical Aspects of Child Abuse and Neglect

Edmund Sherman, Ph.D.

It has been particularly difficult for me to review the literature and research pertaining to the topic of child abuse and neglect. It was with a great deal of reluctance that I examined the material. David Bakan, the author of *Slaughter of the Innocents: A Study of the Battered Child Phenomenon* , suggests that repugnance like my own to examine the phenomenon has played an important role in inhibiting action in child abuse cases. Doctors and others are often accomplices by virtue of their silence, which is an outgrowth of their reluctance to draw conclusions from the medical evidence they see.

The repugnance felt by so many is associated with identification. Child abuse touches everyone personally; every adult was once a child, and every adult is at least potentially responsible for the care of children. Thus there is the possibility of identification with both abuser and victim.

Much of the secrecy surrounding child abuse as well as the failure of earlier societies to do anything about it can be attributed to the fear that to move against parents might "encourage wayward and disrespectful attitudes in the children." Actions against parental authority could threaten social authority according to Bakan's interpretation.

History

Allusions to infanticide are numerous in the Bible. Indeed, Christianity began with a holocaust of the "Slaughter of the Innocents" by Herod's command. To commemorate Jesus's having been spared from this mass execution, Innocents Day was celebrated historically in most Christian countries by ritually whipping children.

As late as 1873, female infanticide was permitted in China. It was reported to be a routine procedure in numerous cultures including the Eskimo, Polynesian, Egyptian, Scandanavian, African, American Indian, and Australian aborigine. In the Hawaiian Islands, it was customary to kill all children after the third or fourth. In tahiti during the first half of the 19th century, two thirds of the offspring were regularly killed.

The classical philosophers, Seneca, Plato, and Aristotle maintained that the killing of defective children was a wise custom. In ancient Greece, according to the census figures, the ratio of boys to girls ran 4 to 1, since it was rare that more than one girl was spared in a family. Roman law gave the father the power of life and death over his children. The law was invoked against children not only in their infancy and childhood, but also in later life. Although Constantine finally abolished the law, he continued to allow the sale of newborn children into slavery.

The old Vikings extended a spear to the newborn boy. If the child seized it, he was allowed to live. Also, in early Scandanavia, a father would expose a child to the winter cold to take revenge for an insult on the part of his wife.

Treatment of children in 19th century England was such that in 1871, the House of Commons appointed a select committee to find ways to prevent the widespread practices of murdering children for the mere purpose of obtaining burial money from a benefit club or putting them out to hire as infants. Officials were also concerned about the mutilation and crippling of children to enable them to beg for adults.

A child's life prior to modern times was uniformly bleak. Virtually every child-rearing tract from antiquity to the 18th century recommended the beating of children. In recent studies, researchers have found no examples of discipline from this period in which a child wasn't beaten, and hundreds of instances of not only beating, but battering, often beginning in infancy.

As late as the 19th century in Eastern Europe, if the newborn was allowed to live, parents would salt it and then bathe it in ice water to harden it. The baby was tied up tightly in swaddling bands for its first year, supposedly to prevent it from tearing off its ears, breaking its legs, touching its genitals or crawling like an animal. Traditional swaddling, as one American doctor described it, "consists in entirely depriving the child of the use of its limbs by enveloping them in an endless bandage, so as to not unaptly resemble billets of wood, and by which the skin is sometimes excoriated, the flesh compressed, almost to gangrene . . ."

Swaddled infants were not only more convenient to care for, since they withdrew into themselves in sleep most of the day, but they were also more easily laid for hours behind hot ovens, hung on pegs on the wall, and, wrote one doctor, "left, like a parcel, in every convenient corner."

Urbanization, industrialization, and technological change, by changing the value of children and parents to each other, affected the child abuse situation.

In the 19th century parents sometimes maimed their children so they could be used to beg or be sold to circuses. Children of five years of age upward were worked 16 hours at a time, sometimes with irons riveted to their ankles to keep them from running away. One 19th century German schoolmaster who kept score reported administering 911,527 strokes with a stick, 124,000 lashes with a whip, 136,715 slaps with his hand, and 1,115,800 boxes on the ear. The beatings described in most historical sources began at an early age, continued regularly throughout childhood, and were severe enough to cause bruising and bloodying.

Clear recognition of the existence of child abuse may be dated in the United States from the Mary Ellen case in 1866. It was not the Special Prevention for Cruelty to Children, but the ASPCA which intervened in this case of extreme child abuse. The court removed her from the home of her adoptive parents on grounds that she was a member of the animal kingdom and came under animal cruelty laws. Following this case, the New York Society for the Prevention of Cruelty to Children came into being in 1871.

The development of the objective X-ray photograph played a large part in overcoming the profound mental resistance to recognizing child abuse as a reality.

In 1946, John Caffey, a physician at the College of Physicians and Surgeons at Columbia University and Babies Hospital, published a paper on a "syndrome" in infants characterized by head injuries accompanied by fractures in the bones of the arms and legs. A few years later, Frederic Silverman (1953) published a paper more explicit than Caffey's. He noted that the cause of such injuries could hardly be anything else than a severe blow of some kind.

In 1962, six physicians including C.H. Kempe and Silverman published a paper presenting the problem as a medical syndrome in the Journal of the American Medical Association. They called this "disease" the "battered child syndrome." They reported a nationwide survey of 71 hospitals and 77 district attorneys which identified 749 children who had been victims of abuse of which 78 died (over 10%) and 114 had suffered permanent brain damage. The die was thus cast for formal medical recognition of the child abuse syndrome.

David Bakan feels that most child abuse is a drive toward infanticide. Symbolism in the best known lullaby is blatant:

> *Hush-a-bye, baby, on the tree top,*
> *When the wind blows the cradle will rock;*
> *When the bough breaks the cradle will fall,*
> *Down will come baby, cradle and all.*

The newness of the ability to feel empathy toward children was made clear from a 5 year study recently compiled by Lloyd DeMause and his colleagues. (Reported in *Psychology Today*, April 1975, pp. 85-88, "Our Forebearers Made Childhood a Nightmare").

The further back in history they went, the lower the level of child care they found, and the more likely children were to have been killed, abandoned, whipped, sexually abused and terrorized by their caretakers.

Good parenting is something that has been achieved only gradually over centuries, as generation after generation of parents tried to overcome the abuses of their own childhoods by reaching out to their children on more mature levels of relating.

Throughout history, an adult has had three major reactions to a child who needs its care:

1) the projective reaction consisting of using the child as a receptacle for the adult's unconscious feelings.

2) the reversal reaction occurring when the adult uses the child as a substitute for an adult figure who was important in his own childhood

3) the empathic reaction, a late historical acquisition, occurring if the adult is able to empathize with and satisfy the child's needs

The first two reactions occured simultaneously in parents in the past, producing a strange double image of the child in which it was at once both bad (projective) and needed (reversal). The further back in history one looks, the more evident these reactions are and the more bizarre the prevailing attitudes toward children.

However, as we shall see, these two reactions are still very much prevalent today in known cases of abusive parents in our protective service caseloads.

Operating on the assumption that most abusers were abused as children, Bakan claims:

> Because child abuse victims in their childhood learn to abuse children quite directly, they are filled with a sense of the moral righteousness of what they are doing.

The internal injunction in an abusing parent has a kind of moral imperative associated with it which is hard to match. His sense of the righteousness and justice of the act derives from the fact that he himself was so punished in his childhood, and develops the idea that such actions were justified.

> Psychologically he has a license from his own superego to abuse his child, which is irrevocable, handed down to him at the time he was abused by his original superego figure. (Bakan, p. 116)

In essence, every time a child is punished by the use of violence he is being taught that the use of violence is a proper mode of behavior.

There is apt to be a profound self-hatred on the part of abusing parents coming from these childhood feelings, and to cope with this, they may project these feelings onto their own child as a loathsome extension of themselves.

Research on physical punishment in general (not only children) is contradictory. Most studies report more use of physical punishment by working-class parents (Bronfenbrenner 1958, Kahn 1968) but some find no difference. Lack of resources has been one explanation for these findings as has more frustration among the lower classes. The willingness and ability to use violence is seen as a "resource" and a family member can use this resource to compensate for lack of other resources such as money, knowledge, and respect. In keeping with this train of thought, Dr. Rowene Brown stated recently at a forensic conference that the number of child abuse cases has risen since the start of the recession. More men are out of work and are at home.

Steele and Pollock in "A Psychiatric Study of Parents Who Abuse Infants and Small Children" state:

> Child abusers have been described as immature impulse-ridden, dependent, sado-masochisic, egocentric, narcissistic and demanding. Such adjectives are especially appropriate when applied to those who abuse children, yet these qualities are so prevalent among people in general that they add little to specific understanding. Categorical psychiatric diagnoses contribute little more and do not answer the crucial question of why a certain parent abuses children. (Steele and Pollock, p. 95)
>
> It is obvious that they expect and demand a great deal from their infants and children, Not only is the demand for performance great, but it is premature, clearly beyond the ability of the infant to comprehend what is wanted and to respond appropriately. Parents deal with the child as if he were much older than he really is. Observation of this interaction leads to a clear impression that the parent feels insecure and unsure of being loved and looks to the child as a source of reassurance, comfort and loving response. It is hardly an exaggeration to say that the

parent acts like a frightened, unloved child, looking to his own child as if he were an adult capable of providing comfort and love. This is the phenomenon described as "role reversal." They define this as a reversal of the dependency role, in which parents turn to their infants and small children for nurturing and protection. We see two basic elements involved - high expectations and demands by the parent for the infant's performance and a corresponding parental disregard of the infant's own needs, limited abilities, and helplessness - a significant misconception of the infant by the parent.

The child is not perceived as a child, but some symbolic or delusional figure and as the portion of the parent which the parent wishes to control or destroy or in other parents who are extremely infantile an and wish to be babied themselves who before resent the dependency and needs of their child and express this resentment in hostile ways.

Kaufman believes these parents "project much of their difficulty onto their child and feel that the child is the cause of their troubles and they attempt to relieve their anxiety by attacking the child instead of facing their own problems." (Steele and Pollack, pp. 95-96)

Examples of this high parental demand combined with disregard of the infant are the following:

Father speaking of his 16 month old son - "He knows what I mean and understands it when I say 'come here.' If he doesn't come immediately, I go and give him a gentle tug on the ear to remind him of what he's supposed to do." In the hospital, it was found that (the boy's) ear was lacerated and partially torn away from his head.

A young mother: "I have never felt really loved all my life. When the baby was born, I thought he would love me; but when he cried all the time, it meant he didn't love me, so I hit him." (Her child, age 3 weeks, was hospitalized with subdural hematomas). (Steele and Pollack, p. 97)

Without exception in the study group (60 families) of abusing parents, there is a history of having been raised in the same style which they have recreated in the pattern of rearing their own children. They often related to them as though the children were adults capable of providing comfort and love. This is the phenomenon described as "role reversal." They define this " as a reversal of the dependency role, in which parents turn to their infants and small children for nurturing and protection." We see two basic elements involved - high expectation and demand by the parent for the infant's performance and a corresponding parental disregard of the infant's own needs, limited abilities, and helplessness - a significant misperception of the infant by the parent.

The child is not perceived as a child, but some symbolic or delusional figure and as the portion of the parent wishes to control had experienced severe abuse in the form of physical beating from either mother or father. *All* had experienced, however, a sense of intense, pervasive, continuous demand from their parents in the form of expectations of good, submissive behavior, prompt obedience, never causing distress, etc. Such parental demands were felt to be excessive, not only in degree but possibly more importantly, in their prematurity.

Everything was oriented toward the parent, the child was less important. As a result the child was made to feel inept, inadequate, unloved and unlovable. It can be seen how such a childhood can lead to adult insecurity and a repetition of the same cycle with their children.

Helping People Who Cannot Manage Their Lives

Irving Kaufman, M.D.

When Sigmund Freud first began to treat neurotic patients, he was surprised to find that despite all their verbalized wishes for help they came late for appointments, were irritable, complained that the therapy was taking away something valuable such as their creativity, and in general made it very difficult for treatment to proceed. Seeking the reasons for this resistance to treatment, he found that the patient's pathology was serving important functions in his psychodynamic balance, and that, therefore, in alleviating symptoms the therapist had to take into consideration what he was doing to the person in the process. This discovery led to the focus on ego psychology in contrast to an earlier focus on symptom relief.

For a long time, Freud and the early psychoanalysts felt that there were only certain types of people who could be treated successfully. These were the people who had enough motivation for change and a strong enough ego to tolerate the anxiety that the treatment aroused and to face their conflicts. Orthodox psychoanalysis is still primarily geared to this type of patient.

However, if these were the only people offered treatment, the vast majority of people who need help with their emotional problems would be deprived of it. Actually, the classic psychoneurotic client makes up a relatively small proportion of any psychotherapist's caseload, whether in a social agency or in a private psychoanalytic practice. An increasing proportion of people referred for help are people having difficulty in the management of their lives. For such persons, the traditional psychoanalytical techniques and methods have proved to be highly inappropriate. Therefore, psychotherapists have been trying to work out other more effective methods of treatment.

The core issue has to do with the diagnosis. Ideally, scientific diagnosis requires identifying the etiological agent which produces a specific kind of pathology, runs a definable course, and responds to a specific kind of treatment. To some extent some etiological factors in emotional disturbances can be identified, but for the most part they cannot. This is because an etiological factor in emotional disturbance is much more complicated than the virus, bacteria, or tumor at the base of a physical illness. In the "unmotivated," "hard-to-reach" families and individuals which comprise a protective service caseload, for example, a multitude of different etiological factors appear to be involved, even in persons with similar types of pathology.

The classic psychoneurotic patients, corresponding to those described by Freud, are functioning at a developmental level having certain specific characteristics. They are able to use language as a major means of communication. Both the client and the therapist expect a logical connection between the thought and behavior. But persons whose personalities are fixated at more primitive stages of development have less capacity to communicate their thoughts and feelings through words. To a large extent they use behavior as their means of communication.

There are only four possible ways any person can express himself: (1) Through words; (2) through affect; (3) through behavior; and (4) through bodily reactions. The clients seen in social agencies such as a protective agency may use all four of these ways of communicating to some extent. However, many of them use behavior as the dominant mode of expressing their problems, and, in turn, require behavioral response from those who would help them deal with their problems. Instead of developing symbolic symptoms, such as an arm paralysis, or loss of speech, a phobia, or an obsession, such people express their problems by beating up their children, deserting their husband or wife, drinking to excess, walking out on their jobs, or in other forms of behavior which get them into difficulty with society. The children play truant from school; they steal; the girls become pregnant; the parents neglect their children.

Because behavior results in social difficulties, however, does not mean that it is based exclusively on social deprivation. Psychological and social factors are usually intertwined in the etiology of such behavior. Direct manipulation of the social environment is

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as ineffective in treatment as direct manipulation of psychological symptoms. Hypnotizing a person and curing a conversion reaction may relieve a physical symptom, but in some instances may produce more serious symptoms. Similarly, taking a person from a slum and putting him into a "better" but unfamiliar neighborhood may not cure his social and psychological difficulties. An intermediate step is usually necessary to help people with behavior problems benefit from social improvements.

Difficulties in intervention

This intermediate step is motivation. Most people who work in the mental health fields come from middle class backgrounds. They are used to dealing with a client in terms of their own self-image — as someone who can be dealt with in a rational way. But in many social agencies, particularly protective agencies, they find clients who have come for treatment under external stress, or who have been forced into it by a complaint from a neighbor or by an order from a court. Even enough motivation to seek help, therefore, does not exist.

Intervention by a psychiatrist, social worker, or psychologist in an attempt to help such people overcome their problems can mean something very different to these people from what it must mean if it is to be therapeutically effective. The prospect of verbal interaction threatens to interfere with their habitual mode of functioning and so may arouse a great deal of anxiety. Even though their overt disturbance may be a cry for help, they may see the person who comes with an offer of help as someone who threatens to take away their familiar way of relieving anxiety.

What does one do to get help to such people?

Reaching the client is relatively easy when he has come to the therapist of his own volition, saying "I have a problem...I want help to overcome it." Such a client comes regularly for appointments, and even though he may show resistance he works on his problems. It is quite another thing when the therapist, usually a social caseworker, must go to interview a client who has not sought his help and who acts as though the therapist were a nuisance or a pest. The treatment problem often becomes even more complicated because of the therapist's own counter-reaction to the negative reaction of the client. In addition, the therapist may feel uncomfortable about imposing his ideas and values on an unwilling client, unless the client is obviously psychotic and dangerous to himself and others, or is severely abusive to his children.

Not many people would say that a parent has the right to break a child's bones or fail to feed him. However, in many neglect cases the issues are not so clear cut, and the caseworker may wonder whether he is imposing something that is not appropriate and whether he is acting out of his own, rather than the client's, needs. These are fair and appropriate questions which a therapist should always ask himself. Nevertheless, the caseworker in a protective agency has a responsibility to determine whether the client is dangerous to himself or to his children — whether intervention is necessary to prevent serious family pathology.

Being rejected by the client may be hard for the caseworker to take because of his own emotional investment in his work. A resultant feeling of discouragement may make it difficult for him to pick up and deal with the core problems of the client. Partly because of his own discouragement, the caseworker may come to believe that the client does not want to change — in other words, is "unmotivated." When the caseworker is called at all hours of the day and night because of emergencies in the same family — the husband is drunk, the daughter pregnant, the son picked up by the police — he might wonder when it will end, or whether it will ever end, and how he will ever do anything for the family. This is particularly true if the agency environment implies: "These are unmotivated people, get rid of them. We have to save our time for people who wish help." On the other hand, an agency environment which gives the caseworker emotional support and recognition for his efforts in dealing with such very difficult people can help lessen the caseworker's feeling of discouragement and make a tremendous difference in his capacity to cope with the problems they present.

Personality structures

What is the psychic structure of the people who express their emotional problems by unacceptable behavior? Many of them are ambulatory psychotics and even more are persons with impulse-ridden character disorders.

It is easy to make a diagnosis of schizophrenia in a hospitalized client who has hallucinations and is deluded, denudative, and assaultive. However, it is not so easy to diagnose the condition of the disturbed persons with less overt symptoms who are so often seen in social agencies. Anna Freud has pointed out that the ego is a dynamic structure which organizes various defenses depending on the stress it is undergoing.[1] These can be defenses against defenses. Moreover, the same person can at one time exhibit a neurotic pattern of defense and at another time a more nearly psychotic pattern. Such persons might be called "borderline psychotics." They include:

1. The schizophrenic group. Classical schizophrenic patterns are isolation, withdrawal, regression, and the use of primary process thinking. Such clients tend to view others as threatening objects, the extreme response being kill or be killed, eat or be eaten, destroy or be destroyed.

If the therapist has a patient who says he is hearing a voice telling him to kill, diagnosis presents no problem. However, a client of a protective agency who views a 3-month-old baby as a horrible monster out to destroy him, although equally psychotic, presents a different diagnostic picture. He may pick the baby up and throw it on the floor and jump on it and kick it, but the next day when brought into court, give a rational story about having lost his temper. Often such a person can hold a job or keep a house clean.

A review of many cases of child abuse has indicated that many abusive parents exhibit an episodic type of psychosis, characterized in extreme cases by wild outbursts of rage.[2] The persons who gave vent to such outbursts had exhibited many positive capacities — for example, they could handle money, hold a job, or manage a household effectively. However, many of them were quite isolated in the community and their relationships with others showed many similarities to those of classical schizophrenics. The episodic form of their psychosis complicates the diagnosis and treatment of such people, especially because many of them at times can be quite gentle and even affectionate with their children.

Persons of this schizophrenic type are also often seen by caseworkers of suburban family service agencies. Many people in this group are highly educated and function well as scientists, professors, university teachers, or in other respected occupations. Yet in other aspects of their life their behavior differs little from that of the borderline psychotics seen in protective settings.

For example, a family service social worker calling at a home found a husband and wife rolling around on the floor biting, kicking, and scratching each other in front of their children. These people, however, were not directly abusive to their children.

In another case, a woman told a social worker in private practice that her husband had grabbed her in front of her children, slammed her against the wall, and threatened her with a knife, saying he was going to skin her alive and tear out her eyes. He had then dragged her across the room and pummeled her, screaming and raving as he did so. This man was a very successful person in his profession and the wife was a very good housekeeper who functioned effectively in many ways.

Before such borderline psychotic clients can be effectively treated, a diagnosis must be reached. The terminology used is less significant than a determination of the level of personality development, the organization of the defense structure, and the capacity for regression.

2. Character disorders. Persons with impulse-ridden character disorders come to the attention of social agencies even more frequently than persons with episodic schizophrenia. Their personalities are fixated at a level between the more deeply regressed psychotic personalities and the neurotic personalities. Such persons account for the bulk of the caseload in a protective agency — most of the neglect cases. The abuse cases occur less frequently and are more likely to involve psychotic personalities. Persons with character disorders also account for the bulk of court and prison caseloads. Such people have major problems in managing the realities of their lives. For example, they may live in a "cold water flat" with a pastel refrigerator bought on credit, without having paid for the electricity to keep it going. They tend to be especially inconsistent in their child-rearing practices.

Persons of this type usually have received inconsistent treatment in their own lives. Usually they have had just enough care and attention to know that something is missing; but for the most part have lived in an atmosphere of deprivation, especially of consistent affectionate relationships and models for identification. Such deprivation and inconsistency have impaired their ego development and fixated their personalities at an infantile stage of development. They behave much like 2- to 3-year-old nursery school children. Many of them have the charm of such children, but they also demonstrate other childish characteristics. For example, their relationships are transient and fleeting. They can engage in some kinds of group activities, but they are likely to go off in some parallel, lone activity while with a group. They tend to use various kinds of projective mechanisms to cope with their problems and to resort to isolation and to repeated compulsive actions when under stress.

Such persons also tend to postpone dealing with problems directly. It is extremely difficult to get them to carry out a responsibility, however minor, such as going downtown and paying a bill, even if they have been given the money to do so. They may complain about a toothache, be given a dental appointment, and then come up with a reason for not keeping it. They have an enormous amount of difficulty in facing anything involving any stress and tend to use isolation and denial as a way of handling even the simplest daily problems.

Such people also have difficulty in handling their aggressive and sexual impulses.

In normal child development, the child progresses from the direct expression of his instinctual impulses to a gradual neutralization of them through his relationship with the important people in his environment. He then develops an increasing capacity for ego mastery. Persons with an impulse-ridden character disorder have not had the ego-building experience which will enable them to gain gratification out of mastery of their environment. Their resultant tendency to discharge their instinctual tensions through aggressive outbursts or promiscuous sexual behavior creates a multiplicity of problems for themselves and others.

Not only do they come into conflict with the community, but also, because they have not acquired the ability to sublimate, they do poorly in areas requiring this ability. As children, they have difficulty in learning and in social adaptation to school and as they grow older they have difficulty in job adaptation, money management, home care, and care of their children.

Results of pathology

The question can pertinently be asked whether there are some kinds of pathology that make for success in our society and some kinds that make for failure. A certain type of paranoid personality, for example, can be observed in some very shrewd businessmen. A man of this type can outwit everybody and does not care if he harms someone else. He gets his own way, accumulates money, power, college degress, and honors. His particular type of pathology is quite compatible with success as it is defined in large segments of our society.

In contrast, there is the kind of person who cannot sit still in a classroom and cannot concentrate on school work. He trips or punches anyone who walks by. He does not get to school, or to his job, on time. If he has any money, it runs through his fingers. This type of person does not learn in school or achieve success in our culture. Although there are many people of this type in all socioeconomic groups, there is a tendency for such persons to regress to or remain at a low socioeconomic level, regardless of the level in which they start out.

Implication for treatment

What kind of therapy can be effective with persons whose emotional development has become fixated at an infantile level?

Conversation has much less meaning for persons thus emotionally retarded than for people who have achieved higher developmental levels. Therefore, they need a caseworker who can communicate with them in other ways.

Anna Freud,[3] Melanie Klein,[4] and other pioneers in child psychiatry have noted the importance of developing a method of communicating with the child needing treatment. Obviously it is not possible to put a child on a couch and say, "Speak of whatever comes to your mind." The first thing the child would say would be, "What can I do next?" Probably his first thought would be, "How do I get out of here?"

This is also true of adults who are not used to discussing problems of any type with anyone. In some work with children from socially, economically, and psychologically deprived backgrounds who have done poorly in school, it has been found that the children did not know how to communicate their wants or thoughts. The experience of being taken on an adult's lap and being talked to affectionately was an entirely new one for them.[5] Obviously, a psychiatrist or social caseworker cannot put an adult on his lap and give him the child-rearing experience he has missed. However, treatment for an emotionally deprived adult has to be a restitutive process before it can be anything else. It has to supply some of the object relationships and other nurturing and ego-building experiences that have been missing in his life.

The first step is to help such a person build up a recognition of the relationship between cause and effect, the effects on day-to-day living of thinking ahead and planning. For this reason, much of the necessary treatment of families in neglect cases may seem to be at superficial levels.

For example, a mother appears unable to realize that in order to provide breakfast for a child it is necessary to have some milk or cereal in the house — not because she does not have the intelligence to know this, but because her own infantile needs are preventing her from thinking of the needs of the child. The restitutive process involves giving her an experience with someone who goes through the thinking and planning with her as an ego-building process. Trying to deal with her unresolved hostility to her parents or other conflicts may have a place at a later stage in treatment, but not until she has been shown by example ways of dealing with her everyday problems.

Similarly, the person who cannot face going downtown or who cannot keep a dental appointment needs the corrective experience of having a relationship with someone — a caseworker, for example — who not only says, "Here's the money to pay the gas bill," but who also goes along with him on his visit to the dentist.

There are several reasons for recommending this treatment procedure. Verbal communication has relatively little meaning for such persons. They do not have enough ego to face the stress of doing even those things which are to their advantage. They need the experience of having someone at hand who not only cares enough to be concerned about their problems, but who also helps them face and carry through on their responsibilities for doing something about them. In playing this role, the caseworker can help such a person build up a model of behavior different from his accustomed pattern of fright and avoidance.

There also needs to be restitution of a parent-child experience for such a person at a level which he can understand. The caseworker does not play games with his adult clients, but the process of going to see them and having a cup of coffee with them, giving them material things, or just being present and interested, as in going with them to the doctor, provides this kind of restitution.

Unfortunately this type of casework approach to the client has less prestige in the social work profession than the psychoanalytic, interpretive, confrontation sort of procedure. Nevertheless, the therapist must deal with the client at the point where he is. One does not start interpreting personality dynamics and confronting a person with his psychological shortcomings if he cannot plan how to get breakfast for his child or get his clothes ready.

The question often arises: Can this type of planning be called treatment? Of course it can. It is treatment based on a diagnosis of the client's level of development. It is treatment based on what the client needs in the way of ego building. It is exactly appropriate. Although a different type of treatment may be called for as the client progresses, the approach needs to be geared at all times to his level of fixation, the structure of his defenses, and the way he reacts to others.

The agencies

Social agencies deal with many people whose life experiences have been marked by inconsistency, desertion, a feeling that no one cares. Such people often act in ways which antagonize the community. As a result, the development of the social agency structure in most communities has been in response to each of the protrusions of a huge iceberg. As a result, there is a tendency for the various parts of these problems to be dealt with in discordant ways.

While efforts are constantly made to coordinate programs, more needs to be done to give the families served some consistency in approach and in philosophy. For example, one agency may be working with a boy who is in court for stealing; another, with his sister, an unwed mother seeking placement of her baby; and another, with the parents in an effort to help them provide a better home life. All of the agencies may be doing excellent jobs, but such a multiple-agency approach is in effect repeating the same kind of inconsistency which people who have so many problems have experienced all their lives. When people have never had any consistent parental care in their own childhoods — have perhaps been shifted from foster home to foster home — the experience of having a profusion or succession of counselors or authority figures intervening in their family life may merely accentuate their feeling of not being able to count on a continuing relationship with one person who cares what happens to them.

In addition, there is the problem of dealing with the community's antagonism to such people. Because people who are emotionally retarded often do things other members of the community do not like, persons who work with them tend to get discouraged. Some public agency policies seem to reflect a desire to get rid of as many people as possible by giving them a one-way ticket to another State, or by putting those who behave in antisocial ways in institutions in isolated rural areas where they will not disrupt the community.

However, the objective of treatment is to help emotionally retarded people become members of the community and to develop an ability to care about other people. This cannot be achieved by policies which are an expression of hostility and which serve to isolate such people from the community even more than they already are.

The problem of dealing with people who act out their emotional problems is not limited to social agencies which see people from the lower socioeconomic groups. Therapists in private practice see many people from middle and upper class families who behave in a similar fashion. Their children behave very much like the children seen by a youth service board, a family service agency, or a protective service agency. They have the same kinds of learning disabilities, they cannot concentrate on school work or sit still in the classroom, and they make nuisances of themselves. Some of them use drugs, and some of the girls get pregnant.

Therapy is as difficult with these children and their families as with children from lower socioeconomic groups. Their attitude toward authority is equally hostile. They are brought to the therapist's attention chiefly because they are not doing well in school, and their parents are worried that they will not get into a good college. But the parents show the same unconscious drive to perpetuate the children's pathology as do the parents of lower socioeconomic status whose children are in trouble. For example, they do not ask their children appropriate questions. If a boy comes home with a wagon that does not belong to him, they do not ask him where he got it.

No matter what socioeconomic group an "unmotivated" client comes from, therapy to be effective must be based on the following considerations: (1) Diagnosis in terms of personality level; (2) what this implies in regard to the treatment approach; (3) how he is likely to interact with others; and (4) what kinds of direct and indirect social objectives are involved in treating him.

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The Abused Parent of the Abused Child

Sidney Wasserman

Willful intent in parents to injure their own children is an "unthinkable thought" for most of us. Even physicians, persons who seem to be in a position to judge whether violence has been done to a child, are often unwilling to accept the "reality of willful child abuse," according to a recent survey among physicians in the Washington metropolitan area conducted by a group of psychiatrists.[1] A fifth of the nearly 200 physicians questioned said they rarely or never considered the "battered child syndrome" when seeing an injured child, and a fourth said they would not report a suspected case even if protected by law against legal action by the parents. Apparently, they did not believe the evidence would stand up in court.

To accept as fact that some parents intentionally injure their children is difficult and upsetting. Thus, we all tend, like the physicians studied, to give the parent "the benefit of the doubt." There may be many reasons for our reluctance, but one is certainly this — when we accept willful intent as a fact, we must face our anger at such parents and our desire to protect the child, even if we harm the parent. But we cannot effectively intervene to protect an abused child and prevent abuse from recurring unless we understand what it is like to be a "battering parent."

One of the dangers of using the label "battering parent" is the possibility of increasing bias and prejudice against the parent. Labeling a particular person as a "battering parent" can release us from the responsibility of making our response to and attitude toward his actions sensitive to his needs. The temptation is great to think of him as being far removed from those of us who do not batter our children. In so thinking, we keep intact our image of ourselves as righteous.

How easy it is to deny that within all of us lies a potential for violence and that any of us could be unreachable! What is more repugnant to our rational, "mature" minds than the thought of committing impulsive, violent acts against a helpless child? We tell ourselves that the primitive, untempered instincts responsible for such acts could not erupt in us. But stripped of our defenses against such instincts and placed in a social and psychological climate conducive to violent behavior, any of us could do the "unthinkable." This thought should humble us: perhaps we are not battering parents only because conditions do not lead us to commit "unnatural" acts.

No class monopoly

Writers on social phenomena, lawyers, social scientists, and others interested in social problems have long recognized that the phenomenon of parents physically abusing their children has been with us since the beginnings of mankind. Only since World War II, however, has much been written on the subject of unexplained, shocking, and traumatic injuries to children. Since then, too, much has been said and written about the legal confusion surrounding the use of authority and sanctions in instances of apparent abuse of children by their parents.

Historically, the helping professions have viewed physical abuse of children by their parents as the result of poverty, life in the slums, ignorance, and the hardships produced by immigration, war, industrialization, and urbanization. No one can deny that these conditions can be a cause of child abuse. Nevertheless, we are finding that the phenomenon can be found anywhere in society. Once we regarded violence against a child as characteristic of parents in the lower socioeconomic classes. Now we are finding that such behavior is not exclusive with any particular social class but that "better" families can more easily conceal the problem than poor ones. In other words, a sociological explanation by itself is inadequate and simplistic.

Through sometimes frustrating and bitter experience, the professions, and particularly that of social work, have come to see that prosecuting the battering parent solves the problems of neither the child nor the parent. Helping the abused child leads us inevitably to the need to help the battering parent and family. As pointed out by Delsordo,[2] Boardman,[3] Nurse,[4] and others in studies of child abuse, practically all cases of abuse involve longstanding, severe interpersonal conflict either between the parents themselves or between one parent and another member of the family.

Because we are dealing with a complex subject involving many social, psychological, medical, and legal elements, we must narrow

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From "The Abused Parent of the Abused Child", Sidney Wasserman, Children (September/October 1967), pp. 175-179. Reprinted by permission of the author.

our scope and take first things first. Nothing precedes understanding who the battering parent is and what he is. Studies point out that battering parents and families, regardless of class, have certain psychological and social characteristics in common; for example, we are learning more all the time about the severe damage to personality these people suffer. Few are psychotic, but all have marked inability to set up a genuine relationship with another human being. Absorbed by their own hurt feelings, they cannot sympathize with the feelings of others. The nonpsychotic battering parent seldom shows remorse for having hurt his child, but he can be very much concerned about the harm a person in authority might inflict on his own person. When facing a person in authority, he cries out: "What are you going to do to me?"

"Done to"

Obviously, something went haywire or was not touched in the humanization process when such persons were growing up. Apparently, they never had the kind of relations with other people that offers incentives for delaying pleasure or gratification or the feeling that it is worthwhile to yield an immediate, antisocial pleasure for the love and acceptance of another. They have been "done to" both socially and psychologically. A battering adult goes about his daily life with the gnawing, unfulfilled feeling of having been unloved or not having been loved as much as he should have been as a child. His life is focused on his own needs, and he cannot tolerate any frustration to the gratification of those needs. What else can he feel but his own hurt, his own hunger for love? He is anesthetized against feeling compassion for others.

This kind of person, according to Reiner and Kaufman,[5] is unaware that he has a buried feeling of "imbedded depression" because he was emotionally or psychologically abandoned by his parent as a child, an act he interpreted as rejection of himself. Unable to understand such a distressing emotional event and not psychologically strong enough to bear it, as a child he buried the feeling of rejection deep within himself and with it the accompanying depression. Because his use of language was not developed, he expressed his feelings by the only means he had -- his behavior. Explosive, violent behavior became his means of communicating with those around him. When he was violent, he was unable to feel his hurt, his sense of worthlessness, his depression. Denied a consistent, supportive relationship with an adult, he set up a life pattern of aggression and violence — and is now inflicting on others what was inflicted on him. For him the world is hostile and dangerous; it is a place where one attacks or is attacked.

Studies also suggest that the battering parent feels his parents were punishing him when they rejected him and that he is longing for a mother. He wants to be loved, yet does everything to prevent another from loving him. Instead, he is caught in a cycle of violence and rejection. When speaking of his physical attacks on his child, the battering parent strongly defends his right to act as he has. He seems unable to feel love for and protectiveness toward his child. He can be extremely compulsive in his behavior and make unreasonable demands on his child. Cleanliness, for instance, may be an obsession with some. I have heard of a child being mercilessly beaten for putting chicken bones on a clean tablecloth and of an 18-month-old baby being seated with his buttocks uncovered on a hotplate whenever he soiled himself. Such people are way over their heads when they become parents. How can they give a child what they have never had themselves — security, safety, and love?

The hostility sponge

This description is supported by a growing amount of evidence that when a battering parent becomes violent, he apparently is releasing his rage on a particular child, selected to act as the "hostility sponge" for that rage. The parent views the child as a competitor, as someone taking and getting what belongs to him. The child is an unconscious symbol of someone or something that once caused him pain -- a competitive brother or sister, a distrusted parent, his rejected self. Sometimes the parent is reliving a childhood experience that left him traumatized. Some of these parents talk about being rejected by their own parents in favor of a brother or sister.

In many instances the abused child has been conceived out of wedlock. The parent is now punishing him for being the cause of an unwanted marriage. Sometimes a stepfather is the offender. He beats the child for reminding him of his wife's "badness." Or the mother may beat the child because he reminds her of her "badness" or that of that "bad" man, his father, who deserted her when she was pregnant. By beating out the "badness" in the child, the parent beats out his own badness or that of another person who has injured him. In other words, the parent is reacting to his own inner feelings, not to the behavior of the child. The child is the provoker by being what he is — an infant or child demanding attention. It is this demand that provokes the parent.

The use of the child as a hostility sponge may be absolutely essential to the mental balance of the parent, and thus, the child is sacrificed to that mental balance. Removing the child from the home without a well thought-out plan to help the parent and the family may only invite the parent to shift his rage to another child. We can easily get caught up in symptom-shifting without getting to the bottom of the problem -- the parent's need to be protected from himself.

To really help such a parent, we must break the chains he has inherited. To do that, we must clearly understand that intervention should act as a brake on the parent's behavior and that the injuries that bring the attention of the community to join them, are his way of saying -- "Stop me!" The act of rushing a child to a hospital or of beating him in front of neighbors or strangers carries a message to the community -- "Please save me from going out of control. Stop me from going out of my mind. Keep me from -- killing!"

We are gradually realizing that in such cases we are dealing not only with a seriously disturbed person but also with a disturbed family. Once the existence of abuse is ascertained and the degree of imminent danger determined, the parent and the family must be dealt with whether or not the child is removed from the home. Even in cases where law enforcement has been effective and community services have been well coordinated, problems in helping the battering parent and the family remain.

According to Zalba,[6] battering parents tend to deny their actions, the husband or wife of the battering parent protects the other, or the children are too young to explain to outsiders what has occurred in the home. The parents also tend to deny the existence of personal or family problems and to provoke judges, lawyers, and social workers by making impossible demands on them; or they rage at everyone in authority and, sometimes, physically attack them.

Firmness above all

In reaching out to the battering parent, we must keep in mind an important key to his behavior -- his fear of a close relationship. Because he suffered rejection in early life, he wards off human relationships[5]. He has emotionally divorced himself from the significant people in his life. He feels safer with and responds more readily to a relationship that clearly offers authority -- firm but not punitive. In other words, the battering parent can often be reached by setting firm limits and controls on his behavior. Whatever he may say, he needs firm control -- and wants it. In the early stages of trying to reach the battering parent and family, the social caseworker or other helper must make realistic judgments and decisions for and with the parents and family to gradually help them develop a sense of reality.

To provide this basic treatment requires long-term help from a consistent relationship with one person only. Shifting the parent from worker to another only stirs up his basic, deep-seated belief that to get close to another human being is to expose one's self to hurt and abandonment. Deep within, he sees himself as the kiss of death in personal relations. He wants to get close to another person, but he thinks that if he does the person will learn to dislike him and will break off the relationship. For a long, indefinite period, the helping person must stand by and support the parent by setting limits and by providing services through community resources. He must not try to get too close or to expect such a person to unload his innermost feelings, especially feelings he is hardly aware of. For such a person, having limits set on explosive, violent behavior provides the kind of protection a good parent would give. The battering parent must be constantly assured that he will not be allowed to get out of control. At the same time, he must be assured that the worker believes that he does not want to hurt his child, that he is capable of change, and that he wants to be a better parent. He needs to learn what the community expects of him and what choices he has. He needs to be helped to understand clearly that consequences will follow his violent act and what those consequences will be.

A long process

In this long and trying process, such a parent will continually test the patience of the helping person and will use every means to provoke rejection to reassure himself that he will not be rejected. For a long time he will reveal only his unlikeable side. When he is reassured, he will make feeble attempts to plant the seeds of a relationship. Reaching out to such a person makes a very great emotional and intellectual demand on the helping person. The battering parent is very perceptive and can immediately sense insincerity. Actually, the helping person must become the "hostility sponge" instead of the child by letting the parent test him, yet he must never let the parent get out of control.

Psychiatrists, psychologists, social caseworkers, and other persons trained for this work have observed that as treatment progresses and a basic trust is established the battering parent gradually faces up to the depression within himself. With extreme caution, he talks about his deep-seated fear that he is a loser and that people always desert him. Only when his need for violence abandons him and he stops expressing himself through it can he talk about his childhood and begin to come to grips with his problems. Though he improves, he continues to try to provoke the helping person, for he is never convinced that he will not be rejected. However, he does move cautiously toward having a relationship with the helping person, gives up or modifies his violent outbursts, and lets himself be guided toward patterning his actions after the standards of the helping person. In time, the pattern becomes a part of him and a new self appears.

To start and set in motion such a long, painstaking process requires a firm commitment by the community to providing excellent service, a goal not easily attained. To obtain qualified staff members and to train persons specifically as workers are expensive and time-consuming. Often efforts to reach the battering parent are obstructed because workers — nurses, social workers, volunteers — come and go frequently on the staffs of agencies. For the battering parent is likely to regard a change in workers as another experience in rejection. The helping person may leave the staff at the most critical moment — just as the parent is testing the worker to find out if rejection will follow his actions. The parent takes the worker's leaving the agency as proof that it never pays to get close to another person. If only a community or agency could insure permanent service for such troubled human beings!

But life affords few opportunities for permanency. We are all only temporary to each other. That is a human condition, and most people accept it. The battering parent cannot. Plans for helping him must include ways to help him accept this truth. We must be ready to test various methods of working with him, always keeping in mind his deep fear of involvement and loss. We must continue to direct efforts to alert the medical, legal, and social work professions, and all groups who might come in contact with the battering person to the need for continuity in helping him. The challenge is not a small one; social workers are finding that cases involving battering parents as well as other hard-to-reach families are making up more and more of their caseloads.

In addition to individual treatment, working with groups of battering parents and their spouses is also proving effective. Many of these parents are isolated from the community. Having an opportunity to socialize in a group of similarly troubled parents tends to lower their resistance to facing and discussing their problems.[6] Working with such families as family groups has also proved effective.[6]

The community must learn

Beyond the abused child, his parents, and his family is the community around them. Battering parents and their families suffer from a not uncommon malaise often called "community exclusion." In various ways, whether economically, politically, psychologically, or socially, these families frequently suffer exclusion. Unfortunately, when such persons vent their rage on their children and the shocked community retaliates immediately, the family's sense of rejection is increased. A cycle of reciprocal aggression is set in motion and, once set in motion, is difficult to halt. The battering parent often succeeds in provoking hospitals, the police, the courts, and social agencies into treating him as his parents once treated him — the opposite of what he needs. Communities must constantly reexamine ways to set up controls and limits while bringing all families into the community life. When a battering parent has only known "community exclusion," he desperately needs "inclusion" to break the cycle.

Finally, we cannot examine our attitude as a community toward the battering parent without examining what it means to be part of a whole — a State, a nation, or the world. Like it or not, we are bound to each other and our destinies are interwoven. As we try to understand the battering parent, we must look into ourselves to find out what there is in each of us, in our community, our Nation, and the world that the battering parent takes as a sign that what he is doing is permissible.

To answer this question we must face up to the paradoxes in our moral code that condemn violence in one form, permit it in another. Many Americans seem to persistently dismiss from their thoughts and acts a basic truth — there is nothing more precious than human life, or so it seems to me.

The people of the United States have yet to learn how to convert their tendency to violence into compassion and tenderness. We are in danger of losing sight of one of this Nation's major social goals, one on which it was founded, that is, to tap the humanity and creative potential of all citizens and to provide the environment and resources necessary for the individual citizen to realize his creative potential. We possess the potential both for violence and for humaneness, and are capable of acting in brotherhood and with understanding. If this were not so, we would not now be seeking new and different ways of helping our less fortunate citizens. By seeking to tap the humanity and potential for growth of the battering parent and family, we are tapping our own potential for personal, community, national and international growth. We must ever encourage the tapping of this potential.

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[2] Delsordo, J.D.; Protective casework for abused children. Children, November-December 1963.

[3] Boardman, H.E.; A project to rescue children from inflicted injuries. Social Work, January 1962.

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[5] Reiner, B.S.; Kaufman, I.; Character disorders in parents of delinquents. Family Service Association of America, New York. 1959.

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The hardest work in the world is being out of work. There is nothing more difficult or tragic than for a father to return home night after night after an unsuccessful day hunting for a job — a job requiring skills which he does not possess. There is nothing harder than sending one's children to school on an empty stomach. There is nothing harder than living in a slum, than fighting the rats, than pleading with the landlord for heat, than freezing in winter, or than sweltering in summer.

Whitney M. Young, Jr., Executive Director, National Urban League, to the 1965 forum of the National Conference on Social Welfare.

Working with the Parent in Child-Abuse Cases

Sally A. Holmes, Carol Barnhart, Lucile Cantoni, and Eva Reymer

Maltreatment may bear no relation to the child's behavior but relate instead to the parent's negative feelings about himself or his situtation.

Child abuse as a concept is relatively new in Western civilization. Historically, children have been accepted as the exclusive property of their parents, who would give them the kind of care they needed and deserved. Parents know best was the rule. An abused child was therefore believed to be a bad child who needed to be punished. Thus, when men like Rousseau, Pestalozzi, and Dewey began to advocate the rights of children, they presented a strange, unwelcome threat to established society. Gradually, however, society has been forced to look at what is happening between some parents and their children, and too often it is not a pretty sight.

One reaction to child abuse takes the form of a bad case of myopia. There is evidence of this reaction in the fact that the writers could find only two articles in Social Casework in the past twenty years dealing with child abuse. One was by physicians[1] and the other by a social worker not in the family service field.[2] Yet family agencies do work with abusive families. Larry B. Silver, Christina C. Dublin, and Reginald S. Lourie report that of the thirty-four child abuse cases they studied, four of the families were treated by the local family agency.[3] The multiproblem family often includes child abuse as one of its problems. But, in reports, family service caseworkers tend to minimize parental attacks on children. In a major article on work with the multiproblem family, Alice Overton refers to abuse in only one sentence: "He acted the tyrant, often beating the children and demanding complete silence in the home."[4] The success of this case is reported in detail, but there is no mention of whether the beating continued, diminished, or stopped.

A second reaction to extreme child abuse is outrage against the parents, which can lead to a child-snatching approach to the problem: Identify the abuse, punish the parents, and remove the child. This view came into focus early in the last century as society came to realize that there was little legal protection for the child. This fact was graphically illustrated in the State of New York in 1871 when a child named Mary Ellen, who was undernourished, beaten, and chained to her bed, was rescued by a group of church workers. The court case was tried under the law against cruelty to animals because there was no law for the protection of children. Shortly thereafter, the Society for the Prevention of Cruelty to Children was founded in New York City.[5]

It is possible, however, to leap too quickly to the solution of removing the child from his home. Many questions may remain unanswered in this process: How much abuse is enough to require removal of the child? If one child is removed, will a sibling be chosen to be abused? Is the emotional damage of losing a parent greater than the danger of abuse? If the child is removed from his parents, to what is he being removed? Who will care for him? Would he be worse off with no parent or with an abusive parent?

There are times when it is clear that a parent is likely to severely injure or kill a child unless the two are separated. Then, action must be taken to remove the child quickly. More often, however, the danger is less obvious. There is room for doubt, and there is a nagging conviction that there must be a better way. A child may be rescued temporarily, only to be returned to the home eventually to more severe abuse than ever. It seems clear that it is necessary to look beyond our outrage in order to give attention to the needs of the abusive parents. It is known that separation from even a severely abusive parent is traumatic for a child. Might it not in many instances be more helpful to the abused child if more determined efforts were made to focus the treatment on his parents?

With this goal in mind, nine staff members of Family Service of Detroit and Wayne County established themselves as a study group in order to develop into more responsive, sensitive, and skillful caseworkers in the treatment of child-abuse cases.[6] Two members were involved with Parents Anonymous in an agency service to that organization[7]. All members had experience with child abuse in other agencies or in their current caseloads.

For nearly a year, the group met regularly. It began by reading the literature on child abuse, each member reviewing a different aspect. All the members read The Battered Child, Helping the Battered

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Child and His Family and The Neglected Battered-Child Syndrome which became, in effect, their textbooks.[8]

The group then considered case material and reviewed a total of twenty-three cases. Each case had been handled by a study group member, either in a district office of the agency, through Parents Anonymous, or both through Parents Anonymous and in the agency office.

Definition of child abuse

Defining child abuse is not easy. The medical definition emphasizes physical trauma to the child. The legal definition is concerned with the guilt of the parents. Various cultures and subcultures appear to have different standards of what is acceptable treatment for children. The working definition of the study group was developed in relation to the parent's perception of abuse. After inflicting damage to his child, a parent may suffer terrible guilt or he may be so afraid of further harming the child that he is hardly able to touch him at all. The abusive treatment may bear no relation to the child's behavior but relate instead to the parent's negative feelings about himself or his situation. Abuse may be a result of the parent's unrealistic view of the child as the powerful one who fails to meet the parent's needs or is "out to get him."

There is no one kind of abusive parent. Such parents come from all socioeconomic levels and cultural backgrounds, and no one psychiatric diagnosis encompasses the personalities and behavior of all of them. They do, however, share a pattern of parent-child relationships. C. Henry Kempe and Ray E. Helfer describe several conditions under which child abuse is likely to occur:[9]

> The parent was emotionally or physically abused as a child.
> The parents feel isolated, with no one to turn to in time of need.
> The spouse is absent, cooperative with the abuse, or fails to provide support for the marital partner.
> The parent unrealistically expects the child to gratify his own dependency needs. The child is seen as different from other children.
> Some form of crisis, real or imagined, exists that sets the abusive act in motion.

In keeping with its emphasis on treatment of the parent, the study group members found themselves defining child abuse in terms of the abusive parent rather than the abused child. This important difference is particularly significant in handling reactions to child abuse. Although it is impossible for caseworkers to deal with their reactions to the pain and cruelty of abusive acts committed against children, they are on more familiar ground if they can see not only the children, but also the parents as hurting, needy people — the kind of people that caseworkers are professionally educated to help.

Resistance to treating abusive parents

Articles in Social Casework are not the only evidence that caseworkers find it difficult to deal with child abuse. The members of the study group became aware of their own avoidance patterns whenever a group member would relate the more gory aspects of an experience with abuse. It is easy to identify with the child and become angry with the parents. Yet, if the worker happens to have a warm, ongoing relationship with the parent, he wants to deny the abusive act and see only the pleasant side of the parent that is shown, forgetting that, in order to help, he must be able to accept the rage as well as the love in the client.

Abusive parents, however, are likely to be isolated and to suffer from severe deficiencies in interactional skills. The behavior that prevents them from establishing warm relationships with others also makes it difficult for caseworkers to relate to them. Although many abusive parents are charming, likable people, others may be difficult people to like. They may talk too much, they may be critical, they may be withholding and unresponsive. Their insatiable dependency may place heavy demands on the caseworker. The client may go through a series of crises necessitating frequent, tense, and exhausting contacts. Extraordinary outreach is often required, leaving the worker drained and discouraged.

Sometimes it is surprising to realize the subtle ways that client reactions may affect casework. If the client frequently fails to appear, the worker may forget to call back or delay arranging the time for a home visit. If a client speaks of being worried about losing control with the children, the worker may minimize his worry. These difficulties are illustrated by the following case.

> Mrs. A came to the agency expressing feelings of being overwhelmed by her total family situation and by her fear that she could not control her own impulses. The worker focused on Mrs. A's feelings of helplessness with uncontrollable children. Mrs. A. failed to keep the next appointment, and two months later the case was closed. Eight months later, Mrs. A. called. She was seen once on an emergency basis, put on the waiting list, and seen one month later. In the interview, Mrs. A poured out her feelings about her school-phobic, seven-year-old daughter, her own tension headaches, morning chaos when quarreling children

waked her, hiding in bed, problems with nine-year-old Keith, past marital problems, and so forth. The worker selected morning time as the initial focus, but whenever a change in the routine was suggested, Mrs. A would say it would not work. The worker questioned Mrs. A's capacity to change the situation.

The next week, the worker made a home visit. Mrs. A had followed none of the suggestions. Mrs. A later cancelled several appointments.

Three months later, the worker saw Mrs. A once. She was upset about possible mental illness and felt nobody could help her. She did not call back and the case was closed. Five months later, Mrs. A was seeking help at another agency for her child-abuse problem.

In this case, the caseworker did not focus on the client's concern about her lack of impulse control, even though it was expressed in the first interview. The caseworker skirted this difficult area and tried unsuccessfully to help the client without facing this central issue.

Sometimes, even when the parent is being seen for child abuse problems, the caseworker tends to minimize the extent of the abuse, as in the following case.

Mrs. B was referred to the district office through her Parents Anonymous sponsor. In the first interview, the worker noted ambivalent interaction between the mother and child. Mrs. B continually pushed the child away, placated her with food, then pulled the child to her again. As the sponsor had not seen the mother and child together, she had been unable to pick up the negative interaction and had tended to view the mother as "not a real child abuser." She had wanted to screen out the hurt and minimize for Mrs. B her weakness as a parent.

Developing a treatment relationship

The initial contact with an abusive parent may be difficult to begin. Often these clients have experienced severe rejection in their lives and have learned to expect rejection. Extensive outreach may be needed. A parent may seek help for some other problem, afraid and ashamed to admit the abuse. From the examination of cases, the study group identified some clues to alert the caseworker to possible child abuse. When several of these clues are found in the same family, workers should become concerned.

The parent expresses fear of being abusive.
The parent expresses fear of losing control.
A referral source (hospital, school, other agency, friend or relative) expresses suspicion of abuse.
The parent refuses to focus on a child's injury, talking instead about some real or imagined injury of his own, even though the child's injury is clearly traumatic, possibly serious.
A child runs away from home.
Punishment is out of proportion to the behavior, suggesting displacement of the parent's anger.
The parent has unrealistic expectations for the child, particularly if the parent is expecting the child to take a nurturing role toward the parent (role reversal).
Normal child behavior is seen as deliberate abuse of the parent (the child is "out to get me").
The parent asks that the child be placed outside the home.
The home is excessively sloppy or excessively neat.
The child is blamed for family difficulties, such as marital problems.
The parent complains that the child does not even cry when physically punished.
The parent strenuously defends his own parents' bad child-raising techniques.
There is little affection shown between parent and child.
The child, particularly a preschooler, suffers repeated injuries that require medical attention.
There is frequent screaming and demeaning of the child by name-calling — "devil," "bastard," "whore," and so forth.
The client reports that a friend or relative is the abusive parent.

Often, when the caseworker fails to pick up the clues, the client becomes convinced that what he is doing is so terrible that even the caseworker can not talk about it. It is important, therefore, to talk openly about the abuse. At the same time, it is undesirable to have the client's identity revolve around being a child-abuser. There is no point in forcing admissions, nor is it necessary to define and admit to abuse before the problem has been worked on.

Because severely abusive parents are rivalrous with their children, it is important that the caseworker avoid focusing on the child during the early stages of treatment, especially at the time of crisis. In the following example, when the caseworker expressed concern for the child, the child became further endangered.

Mrs. D called late one night to report that she had been beating her ten-year-old John and felt like finishing the job. She was going to run away — take the baby and go to a motel. The caseworker questioned what she had done to John and asked how badly he had been hurt. The caseworker said that if Mrs. D went away she would need to call another community agency to make sure John was cared for. Mrs. D became very angry and accused the worker of not believing or trusting her. She threatened to kill John to prove that she meant what she said. She put John on the phone and he sobbed that his mother was pointing a gun at him.

Defining precipitating factors

Once an abusive parent has been drawn into treatment, how does one offer the help that is needed? The major goal of altering the destructive relationship between parent and child may he facilitated in many ways. One of the first tasks is to find out what is happening. What behavior of the child triggers the irrational response? What are the patterns in the relationship between parent and child? In each of the following examples, the irrational responses of the parents are focused on particular behavior — lessons, eating habits, bed-wetting.

> Mrs. E. beat her ten-year-old son with a belt. She had unrealistic expectations of him. She expected perfect obedience. She expected him to do household tasks that required more skill than a ten-year-old was likely to have. She also expected him to organize his work in a mature fashion. But what upset her most were his repeated school failures. For weeks after a teacher would complain about him, she would sit him down after school each day to do his lessons. He would not do the work, so she would beat him. This behavior continued all evening until the final lashes in bed just before he went to sleep for the night.

> Mrs. F. came in to get help with the management of her child. Her chief complaint was that the child did not eat properly. Mrs. F was concerned about both nutrition and manners. In the third interview, Mrs. F sat down and said, "You know, it's not Betty's eating. There is nothing she could do to please me. I feel that she has trapped me by her very existence."

> Mrs. G. was quite open about her inability to tolerate her six-year-old daughter, Terry. Terry expressed her rebellion through enuresis, which provoked her mother's rejection. Mrs. G threatened "to take off for good." This upset Mr. G who focused his anger against Terry, frequently using physical punishment.

In the next example, the irrational behavior is harder to identify because, instead of attacking the child in anger, the mother withdrew because of her fear of her own violence. In this situation, the irrational response was expressed by keeping an emotional distance between the mother and her child.

> Mrs. H came to the agency when her four-year-old was returned to her from foster care. Mrs. H had abused the child, but never seriously enough to warrent court action. Mrs. H had voluntarily placed the child because she was afraid she might abuse her more seriously. When she came to the agency, Mrs. H was catering to her child's every whim, fearing that if she tried to set any limits on the child's behavior, the child might become angry and that she might retaliate with more serious abuse. Mrs. H entertained the child constantly, yet carefully maintained an emotional distance.

The client and caseworker together try to identify the situations — such as the above response — that seem to set off abusive responses. This effort is the first step toward understanding and controlling the parent's irrational perceptions.

Understanding rage

It is important that clients be aware of the distinction between anger and rage. Anger is the emotional reaction to the present situation in which an individual perceives himself as hurt or mistreated in any way. The person is easily able to identify the reason for his anger and his angry reaction is proportionate to the severity of his perceived injury.

Rage, however, is a well of suppressed anger and fear that has been stored up, often from early childhood, so that its cause can no longer be easily remembered nor identified. It simmers beneath the surface of the conscious mind and is a source of terror to the individual who feels the pressure and fears that the dammed-up emotion may burst forth beyond his control. Often, the rage originates from the terror which the individual felt as a child, bearing the brunt of the uncontrolled violence of his own parents. In such a situation, a child is not only frightened but overwhelmed by his own helplessness. He is not allowed to express his anger at being mistreated; he is forced to submit and suppress his anger. As an adult, he re-creates the scene, only this time he is in the powerful position and can act out against his own child the revenge he longed to gain against his parents. An important step in treatment is the client's recognition of the infantile rage and, if possible, some understanding of its source so that he can find new ways to cope with it.

> About two months after starting treatment, Mrs. J was sitting at home very upset. Her child reached over to comfort her. Later Mrs. J described the incident: "That was my mother's hand touching me. I cringed and ran away from it. I wanted to kill her!" Thus, Mrs. J recognized that

> a major component of her abuse of her child was an acting-out of the rage toward her own mother. In subsequent weeks, Mrs. J remembered many childhood experiences in which her wants were not met, where she was expected to forego her own needs in order to care for her mother, and where she was severely hurt when she failed to care for her mother. As she worked on her current relationship with her mother, Mrs. J found that she no longer had to dedicate her life to the care of her mother. When she could assert herself more effectively with her mother, she could begin to set realistic limits on her child's behavior, without the danger that she would express her pent-up rage against the child.

When an individual is burdened with underlying rage, he becomes fearful of all angry feelings lest they trigger an outburst of the rage over which he feels, at best, only tenuous control. Because he was not allowed to express his anger as a child, he may not know how to express it legitimately as an adult nor even understand that anger is an acceptable, normal emotion. The interaction between the caseworker and the client often provides an arena in which the client is able to experiment with new ways of expressing anger. Clients learn that they may express their anger without threat of loss of the relationship or of physical control. Parents Anonymous group meetings are particularly helpful in this regard.

> Mrs. N phoned to say that she had been hurt by Mrs. O's remarks at a previous Parents Anonymous meeting and felt that Mrs. O did not want her in the group. Mrs. N was encouraged to express just how she felt, and it was then suggested that it was important for her to express those same feelings to Mrs. O at the next meeting.
>
> Supported by the caseworker's acceptance of her feelings, Mrs. N was able, with great difficulty, to repeat to the group what she had said. The worker's role in the group meeting was to help each of the women to clarify how she was feeling and to express these feelings to the others. Mrs. O told Mrs. N that she could accept the fact that her own problems were different from Mrs. N's but that she did want her in the group and she did care for her. As they talked out their misunderstanding, the tension subsided. It was a learning experience for the whole group.

Some clients divide people into "good" and "bad." People either "hate" or "love" them. With such unrealistic expectations and no room for human error, it is difficult to sustain long relationships. Again and again, such clients must be reminded that people feel ambivalent emotions toward others, including both love and hate. These clients have been taught from childhood that they can not be angry with people they love. They were forced to deny the hate and fear they felt toward their parents, often building idealized images of the parents to prove their affection. They carry heavy guilt about the hate, having been taught that there must be only love between the parent and child. One of the goals in treatment is to help clients to understand that feelings of hate and anger do exist in every close, loving relationship. Misunderstandings occur and feelings get hurt. Gradually, clients learn to recognize and explore their own negative feelings and to accept them as a legitimate part of any relationship.

Parenting the parent

Caseworkers are continually faced with the task of meeting parents' dependency needs without infantalizing them. As ways are found to meet their needs, they become better able to perform the role of parent. Because these parents suffer from an overwhelming sense of rejection, it is important always to show them acceptance and concern and to focus on what hurts within the parent. If the caseworker shows concern for the children, the parent is threatened; he immediately feels that the worker can not be concerned for him.

While an extremely dependent client may lean heavily on the caseworker, at the same time he is apt to resent the dependency. The adult part of the client knows the dependent relationship is inappropriate, and negative feelings about past dependent relationships may be projected onto the caseworker. Delicate judgment is required to set limits in a firm but gentle manner, constantly evaluating whether his response is nurturing support or if it goes beyond this to feed the childlike dependency. It is easy to become unduly involved in the client's life, allowing anxiety about the client's behavior to impede his progress toward appropriate independence.

In a group situation, a sibling rivalry may develop, with each member vying for the caseworker's attention and feeling slighted if any member gets extra time. This conflict is a reliving of childhood family experience where parents showed favoritism among siblings. It is important to define limits together.

Educating the parent

Another task of the caseworker is to fill gaps in the parents' knowledge of normal child development. We must evaluate the parents' understanding of what are realistic expectations for the age level of the child. In the following examples, the parents were ignorant of the developmental needs of their children.

> Mrs. V felt that her own life had been severely restricted by lack of a proper education and was determined that

her son would not suffer in this way. Although he was only seven years old, she forced him to sit for hours doing homework, without adequate time for play or exercise. Severe and frequent beatings were used to force the child's compliance.

It was necessary to do a great amount of educating so that Mrs. V could understand the other needs of her child. Because her own needs were so tied up in the child's education, she was encouraged to stay entirely away from any participation in his schooling. As she learned the importance of play and exercise for him, she was able to modify her expectations and greatly reduce both the frequency and the severity of the beatings.

Mrs. W was very angry with her one-year-old child because she kept dropping things from her high chair. When she expressed her frustration about this behavior to her Parents Anonymous group, it was pointed out that this occurrence is common with year-old children. Other group members spoke of similar experiences with their children. When asked the reason for dropping toys, they replied, "The child is out to get you," "They know you don't like it," "They want to show who's boss," and so forth. The caseworker explained that a baby learns about distance this way, by watching things go away from him. He learns about gravity -- that they always fall down, never up -- and that things which go out of sight don't cease to exist but will come back (like peek-a-boo). A baby learns the fun of interaction with others in this first predictable game. The worker pointed out that if a parent gives a child four items to drop and then picks them up, it is less wearing.

When the mothers understood that the game was a valuable learning experience for the child, they felt that they would be able to play it with a great deal more patience, possibly even with enthusiasm.

Expanding life satisfactions

The abusive parent's life is likely to be only minimally satisfying. Such clients usually suffer painfully from low self-esteem and extreme feelings of inadequacy, hopelessness, and despair about their ability to improve their lives. This overwhelming sense of futility and incompetence seriously damages the parent-child relationship. People whose inner resources are so depleted often have few pleasurable activities. They may have internalized the belief that they chould not have fun, that their role as parents demands self-sacrifice and martyrdom, and that to set aside any time for themselves is unimportant or even sinful.

Caseworkers need to maintain firmly that the client deserves to have fun and that it is healthier for the child if the parent leads a satisfying life. A pleasurable activity for some clients may be working toward a definite vocational goal. They may have been thwarted in their vocational plans, may be in unsuitable jobs, or may never have thought of themselves as desiring a job. Caseworkers can help to legitimize the clients' desires and reinforce their effort toward achievement.

Helping parents modify behavior

Many times, clients have adopted behavior which was important to their survival as children but is inappropriate in their role as parents. If parental approval was strongly insisted upon and backed up by physical abuse, for example, approval of others -- even his own children -- may be overwhelmingly needed by the individual even as an adult. Such a client needs to be helped to recognize the inappropriate seeking of approval as a source of trouble. For example, a child may fail to recognize and approve his mother's efforts to please and may be badly beaten. The mother may be thoroughly confused as to her reason for losing control and may need the caseworker's help to relate her need for approval to the inappropriate expectation of her child.

Housekeeping is often perceived by the mother as an important part of her self-concept. In this symbolic role, the mother's housekeeping behavior often becomes quite inappropriate. Compulsive housecleaning may be a fruitless attempt to build or increase self-esteem. In such a case, any action of the child that disrupts the house will be experienced by the mother as a direct attack against her. At the other extreme is the client who is disorganized and compulsively dirty. This mother feels dirty, worthless, and inadequate, and her housekeeping reflects her self-image. In each case, part of the problem may be the mother's impossibly high expectations of herself. In the first instance, no matter how hard she works, she can not satisfy her own high standards. In the second, she feels like such a failure that she is immobilized before she can begin. The goal is to help the client to set up reasonable standards for herself, to learn why housekeeping has become so overcharged emotionally for her, and to improve her image of herself.

Role reversal is one of the most common categories of inappropriate behavior for the abusive parent. Parenting demands a constant giving of emotional support to the child. The abusive parent not only lacks the ability to give sufficient support, but often demands a parenting type of support from the child instead. The parent's insatiable dependency needs are expressed through the constant demands on the child to assume a parenting role so that the parent can assume the role of the dependent child.

Mrs. T habitually spent many hours of her day on the telephone. One day she was upset and called the caseworker to complain that Rose, her year-old child, was whiny and crying. Crying could be heard in the background and Mrs. T said the child had been in the playpen in the bedroom by herself for "about forty-five minutes." She pleaded with the child, "Don't cry now or I'll lose control and come in and spank you."

The caseworker talked with Mrs. T about her feelings and Mrs. T was able partially to understand that the child was upset because she was alone and could sense her mother's rejection. But Mrs. T also felt that Rose was trying to "get" her. She expected adult behavior from her child when she asked her to remain quiet for a long period of isolated play. She asked the child to act the adult part — exert control — so that her mother would not misbehave (come in and spank).

After talking about this and many similar experiences in the group, Mrs. T was gradually able to recognize that she was making unrealistic demands of her child. Slowly, as the group continued to look at what was happening between Mrs. T and her child, the mother began to understand that her child was reacting to demands which were beyond her ability to meet. She was not deliberately out to get her mother.

Mrs. T will probably always feel that her child (and everyone else) should nurture and give to her. She learned, however, that no one can make up for her the nurturing she missed as a child. She must live with that pain and emptiness. She is gradually learning to look elsewhere for the nurturing, to know that she can not expect to receive it from her child. As the mother's demands have become more realistic, the child's behavior has improved, and the relationship has become more tolerable for both parent and child.

Breaking the barrier of isolation

Most abusive parents suffer from the fear that they have no one to turn to when they are in need. Whether the isolation is emotional or realistic, there is a defective communication system and a weak support system within the client's environment.

One of the major values of Parents Anonymous is that group members are available to each other in times of crisis. The group process is used to help members recognize their self-defeating patterns of interaction so that they no longer feel alone and isolated. Group members help each other in such practical ways as baby-sitting and alleviating other environmental pressures. Aid in solving these problems helps parents to feel that someone else cares and will nurture and support them.

Caseworkers need to work also with important people in the parents' lives in order to build stronger support systems within the fabric of the client's private life. Sometimes relatives or friends, made aware of the client's isolations and fears, can develop stronger ties with the client and offer needed support.

Helping parents to allow for setbacks

A major problem for many abusive parents is their low self-esteem coupled with their high demands on themselves, a combination that results in a feeling of defeat. A client may have many strengths and be making substantial progress, yet one setback can throw him into despair and self-recrimination. Over and over, such clients must be reminded that progress is erratic and setbacks must be expected. We are all human and we make mistakes. If it is difficult for an abusive parent to allow his children to make mistakes, it is even harder for him to allow them in himself. In the following example, the caseworker actively pointed out the client's strengths.

> Mrs. X called to say she had hit her child. She was very upset at losing control just when she had been doing so well. She felt she had failed the group and could not return. She said she was not really making progress after all. The worker reminded her that progress is slow and erratic, and they reviewed her improvement, remembering how she had been when she began coming to Parents Anonymous and how much she had changed over time. The worker talked about her desire to control herself and her wish to be a responsible parent. When her child had fled to her the day before she had not lost control. She was trying to improve and the group would continue to support her efforts.

Recognizing the need for placement

Although the emphasis in treatment is to prevent the separation of the child from the parent, under certain conditions such separation may be necessary and, in fact, the most appropriate treatment plan. Temporary separation of the child from the home may be essential as a way of providing safety for the child when other methods of intervention fail. It may also be a way of assisting the parents to work out their problems without the pressures of caring for the children at the same time. Sometimes, of course, permanent placement is necessary.

The factors the caseworker uses in determining whether placement is necessary involve two major areas: the inner resources of the parent and the external support system. Parents who function adequately most of the time will sometimes undergo periods of physical and emotional stress. If there is no one in the extended family or among friends to care for the children temporarily, a short-term placement facility enables the parents who are under personal stress to get away for short periods of time. This relief allows them to mobilize their resources to face some stressful situations in their lives and possibly prevent a full-blown crisis. When parents feel overburdened with their children and feel there is no escape from them, these feelings often precipitate child abuse.

There are times when parents' inner resources are so minimal and external supports so unavailable that the children must be rescued. It is essential to consider what would be gained by removing the child from the home, and what the alternative care would be. Feelings of rejection, abandonment, and guilt may be expected in both parents and children. These feelings need to be worked out in preparation for the separation so that the child will not go into placement with his original problems compounded by the trauma of separation.

Relationship between agencies

There are often many agencies involved with an abusive family — school, juvenile court, protective services, guidance clinic, hospital, and so forth. Unfortunately, the multiplicity of agencies involved does not in itself guarantee more effective service to the family. It is important that each agency be clear about its role in the total service.

The authoritative agency is primarily concerned with the protection of the child. Although the caseworker in that agency may recognize that the best way to protect the child is to help the parent, his primary function is to assure the child's safety in whatever way may be necessary. The caseworker in the voluntary agency, on the other hand, can focus on helping the parent deal with the problem of child abuse. Even when his focus is on the parent, however, he must be sensitive to the child's welfare to assure that the child does not become severely damaged while he is treating the parent. The two points of view are complementary. Yet, the manipulative client may distort and play one agency against another in a self-defeating way. It is essential that staff members of the various agencies consult with each other frequently.

A family agency is a voluntary service whose clientele is generally limited to people who recognize that they have problems and are able to work on them without the direct, ongoing pressure of a court or other authoritative agency. For those families who are unable to meet the community's child-care standards without frequent and firm use of the law, the greatest cooperation possible is demanded of all community resources. Not only must social agencies be aware of their needs, but churches, neighbors, schools, the extended family, and formal and informal groups should help in building up the support systems necessary to sustain these dependent parents through the difficult years of child-rearing.

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[1] Larry B. Silver, Christina C. Dublin, and Reginald S. Lourie, Agency Action and Interaction in Cases of Child Abuse, Social Casework, 52:164-71 (March 1971).

[2] Maurice J. Boisvert, The Battered-Child Syndrome, Social Casework, 53:475-80 (October 1972).

[3] Silver, Dublin, and Lourie, Agency Action and Interaction, pp. 166-67.

[4] Alice Overton, Serving Families Who "Don't Want Help," Social Casework, 34:304-8 (July 1953).

[5] Ray E. Helfer and C. Henry Kempe, The Battered Child (Chicago: University of Chicago Press, 1968).

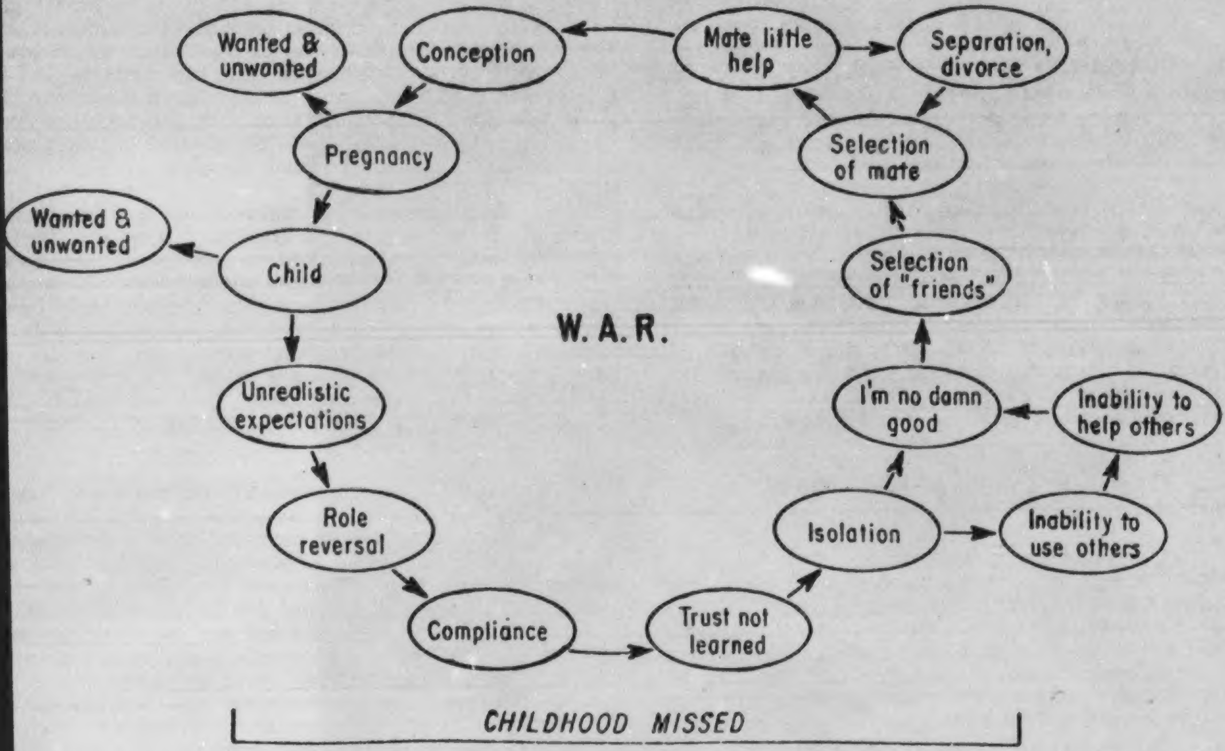
[6] In addition to the writers, other members of the study group included Amethyst Carswell, Betty Istratoff, Francis M. Moynihan, Francena Tinsley, and Ellen Whitehead.

[7] Parents Anonymous is a self-help group for parents who abuse their children and want to stop. It started in California in 1969 and rapidly developed into a national organization. Members join small groups that meet weekly with a professional to discuss individual progress. Members help each other by providing help at the time of crisis and by offering the support of a friendship group. For further information about Parents Anonymous, see Lucile Cantoni, The First Two Years: Parents Anonymous of Michigan (Detroit: Parents Anonymous of Michigan, 1974).

[8] Helfer and Kempe, The Battered Child; idem, Helping the Battered Child and His Family (Philadelphia: J.B. Lippincott Company, 1972); and The Neglected Battered-Child Syndrome (New York: Child Welfare League of America, 1963).

[9] Kempe and Helfer, The Battered Child, pp. 57-62.

World of Abnormal Rearing Cycle


Wanted &
unwanted
Conception
Mate little help
Separation, divorce
Pregnancy
Selection of mate
Wanted &
unwanted
Child
Selection of "friends"
W. A. R.
Unrealistic expectations
I'm no damn good
Inability to help others
Role reversal
Isolation
Inability to use others
Compliance
Trust not learned
CHILDHOOD MISSED

From A Self Instructional Program of Child Abuse and Neglect, by Ray E. Helfer, M.D. By permission of the author.

Parents Who Hate

Leontine Young

A tall, well-dressed man sits in the office of a social agency talking to a caseworker. She has called him because a neighbor has reluctantly complained that he beats his children with excessive brutality. Mr. Nolan speaks with quiet emphasis. His language and diction indicate an educated man.

He is explaining that he loves his children. His wife indulges them too much, but this is really the only problem. Of course, the children have to obey his commands, and when they don't he punishes them. One evening recently he told his four year old son to go into the basement and stay there. The little boy went down the stairs and ran quickly back. It was very dark, and he was frightened. "I spanked him and told him to go back," explains the smiling father. "He went down the stairs and again ran back to the light, frightened, so I spanked him again and sent him back. He returned four times and each time I spanked him harder. The last time he stayed down."

"And what did the little boy do that you punished him so severely?" asked the caseworker.

A look of blank surprise comes over Mr. Nolan's face. He stares at the caseworker, and when he speaks his voice is for the first time uncertain. "I don't remember. I can't think what he did." A wariness appears in his eyes, and he remarks that his time is short and he must leave shortly.

Mr. Nolan was a successful man and well educated. He was able to afford a comfortable home for his family, and there was no financial strain. His wife was a college graduate. There were four children, one still an infant. Mrs. Nolan looked older than her husband, and her face had a vague, uncertain expression that was reminiscent of a sleepwalker.

When she talked to the caseworker, she was worried and confused. Sometimes, she explained, she hated her husband for what he did to the children, and then again she thought perhaps she was wrong, perhaps it was all right to punish children like this. Only he beat them so terribly for nothing. One of them accidentally stepped on the kitchen floor which was still wet from washing, and his father beat him until he was a sodden, quivering bundle of pain. Still, her husband told her that she indulged the children too much. It was true she was not so strict with them as he was. He accused her of favoring Donald, the oldest child, and perhaps she did.

Lines of anxiety tightened her face as she told the caseworker, "He wants to break Donald, I know it. Donald is like me. He doesn't need outside recognition. He gets his security from inside himself. He only needs to know I care about him." Donald was a bed wetter, and this worried her. He was getting to be a big boy. Her husband told her enuresis is normal, and she had been reading too many books. She thought the family needed help and sometimes she wished the court would take the children away and protect them. Only she wouldn't want her husband punished. She loved him, and she would never want anyone but him.

A wistful look momentarily softened her face. When she was young, she told the caseworker, she was gay and loved to go out, to dance and join in parties. For a few moments she reminisced, and the memory of pleasure, perhaps greater in retrospect, glimmered in her expression. Then it was gone. Her shoulders drooped again, and she said wearily that perhaps her husband was right. He told her she had never grown up, that she remained a child with little sense of her true responsibilities. The trouble was she would get so confused. She would think sometimes that he was right and that she was a fool. Then again she would get so angry, and not be sure he was right. Sometimes she hated him, and sometimes she felt ashamed for feeling this way about her own husband. He provided a comfortable living for his family. He didn't drink or run around with other women. He was successful in his work and respected by his employer.

Mr. Nolan saw no further need to talk with the caseworker. There was no problem except for his wife's weakness and he was used to this.

From Wednesday's Children: A Study of Child Neglect and Abuse, Leontine Young, (New York: Mc Graw-Hill Book Company, 1964) pp. 43-45. Reprinted by permission of the author.

Not long after this interview Donald went to the hospital with a broken leg, and his father explained he had accidentally fallen downstairs. The neighbors said they had heard the father beating him. Mrs. Nolan and the children said nothing. Donald refused to answer questions. His face was white and strained and his small body stiff with tension. At night he had frequent nightmares and screamed in his sleep. He jumped at unexpected noises; when someone approached him unexpectedly and without warning, he cried out and then was instantly silent.

A few months later Mrs. Nolan attempted to kill herself. Her husband said it was because she was subject to spells of depression. He had done all he could to give her strength and he would continue to care for her. He would take over more of the care of the children and relieve her of the strain and responsibility. He loved his children, he explained, although he observed in an unwary moment that he hated Donald because he was like his mother.

The Role of the Social Worker in Child Abuse and Neglect

The worker and the ways in which feelings about self and others affect professional practice

The Concept of Authority and Its Use in Child Protective Service

Shankar A. Yelaja

Authority, an integral part of protective service, is used effectively when the social worker understands the meaning of the authority vested in him and can communicate through empathy with his clients.

Authority — its legitimate place in the worker-client relationship and its use as an enabling factor in the helping process — has been a subject of some controversy in the professional literature of the past. Social caseworkers, especially those in authoritarian agencies, have wrestled with this issue in an effort to resolve what seems to be a dilemma. A quick review of the professional literature on the subject of authority and its use in social work practice would, however, indicate a shift in emphasis. Although we have settled the basic controversy of whether social casework based on authority is an integral part of social work practice, the efforts now seem to be directed increasingly toward the development of a better understanding of how authority can be used as a dynamic in a growth-inducing experience for a client who is resistant to help and comes involuntarily to a social agency.[1]

The Editor of Social Casework, summarizing this trend, observed:

> "...current writers are stressing that an authoritative relationship, which always has in it negative connotations for the client, can be used constructively in offering him certain services, and that the protective role can in time be modified, permitting the development of a dynamic and positive relationship through which the client can develop emotionally....It seems to close the debate as to whether casework can be practiced in an authoritative setting. The question now is how the client, in any setting, can be understood, helped, supported, and 'reached' emotionally."[2]

In keeping with the contemporary trends of thinking, this paper[3] is presented with two objectives. First, it seeks to clarify in depth the concept of authority from interdisciplinary standpoints. Second, it attempts to discuss some of the problems underlying the use of authority in child protective service.

Authority in the helping process

The central theme of this paper is based on the premise that authority as a power of communication can be used as a dynamic in the helping process, depending upon the degree to which the caseworker understands the meaning of authority and also the degree to which neglectful parents are willing to identify the positive aspects of authority for enhancing their parental motivation. The Social Casework Editorial Note has emphasized some of the positive aspects of authority, recognizing that authority has a greater potential of producing negative feelings, but that these can also be utilized in the helping process.[4] The professional literature of the past is replete with the discussion of this aspect of authority, but very little emphasis seems to have been placed on viewing authority in light of its positive and benevolent elements.

Child protective service

I shall discuss child protective service as background for discussion of the concept of authority. In the social agencies offering service to neglectful parents, one finds certain distinctive characteristics in the helping process that differentiate it from that used by "voluntary-client" agencies. Although most social agencies are structured to offer services to clients who come to the agency of their own initiative to seek help for their problems — individual or social — the nature of neglect makes it obvious that the parent who has been neglecting his child does not request the service of his own volition, but that the request for service comes from someone else. Protective service to children is, therefore, initiated by the agency, and, unlike service from other social agencies, it cannot be withdrawn when the parent refuses or is unable to use the agency's help. The agency is obligated to continue work with the parents as long as conditions of neglect persist, although in some instances casework service might be terminated because of the parents' refusal to cooperate. In such instances, however, the agency would evaluate the situation to determine the need for court intervention.

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From "The Concept of Authority and Its Use in Child Protective Service," Shankar A. Yelaja, Child Welfare, (November 1965), pp. 514-522. Reprinted by permission of the Child Welfare League of America, Inc.

Protective services for children are established under state laws.[5] Even though in some states responsibility for protecting children is delegated to private social agencies, it still remains primarily the responsibility of the state, and most of the state governments have enacted laws covering this. Since the basis of social service to parents neglecting their children is within the framework of the law, it therefore carries with it community sanction and a range of normative values governing an acceptable standard of child care. These standards of child care have changed from time to time and are subject to further modifications. Agencies providing protective service, however, operate on a given set of standards, and the parents' motivation for improvement in child care is measured against these standards, which continue to serve as guidelines throughout the casework service.

Although the authority of child protective agencies emanates from law and carries with it the inherent threat of separation of children from parents when conditions of child neglect persist, the very fact that the protective caseworker is willing to help the parents without invoking legal action and that the community accepts that parents have a right to an appropriate service before they are adjudged neglectful diminishes the importance of legal authority. It becomes obvious that the concept of authority has a range of meanings of which an examination would be worthwhile. Such an attempt is exceedingly important to the understanding of how authority can be used most helpfully in developing impaired parental capacities and strengths.

Ranges of meaning

What are the various dimensions of authority? What is the range of its meaning, and how can these be understood in the context of the worker-client relationship and social work practice in child protective service? In our attempts to define authority, some dependence on sociologists, psychologists, and behavioral scientists seems to be justified and, to some extent, necessary because of their extensive work on the subject. A note of caution is necessary, however, when applying their knowledge and findings to social work practice. It must be remembered that most of these social scientists have studied authority with a bureaucratic model as background; the findings may not always fit into the social work model based on democratic values.

Power in authority

Authority, as defined by Parsons, "is an institutionally recognized right to influence the action of others, regardless of their immediate personal attitudes to the direction of influence. It is exercised by the incumbent of an office or other socially defined status..."[6] Another useful definition of authority derived from sociological analysis is given by Lasswell and Kaplan, who offer a series of definitions of significant concepts such as influence, power and authority.[7] Power is only one of the operative values on which authority relations are based, but it is one of the most important ones. According to these two authors:

> "Authority is thus the expected and legitimate possession of power. We say 'expected' because the actual power structure does not necessarily coincide with that described in the political formula; and 'legitimate' because the formula is the source and basis of legitimacy. To say that a person has authority is to say not that he actually has power but that the political formula assigns him power ....and regard(s) his exercise of it as just and proper."[8]

Mencher, however, prefers to define authority as "the power to induce changes in, or to exert control over, the behavior of another. Its influence is dependent upon how it is perceived or accepted by those to whom it is directed."[9]

Although power is one important ingredient of authority, it alone does not always reach the desired objectives of authority. Power is the actual ability to control, which may or may not be a right based on a particular position and it may result from such diverse factors as prestige, physical coercion, persuasion, and class. As Merton points out "...positions in the class, power, and prestige hierarchies contribute to the potential for interpersonal influence, but do not determine the extent to which influence actually occurs."[10] "Thus, authority is the potentiality to influence based on a position, whereas (the) power is the actual ability of influence based on a number of factors including, of course, organizational position."[11]

Implicit in all of these definitions is the important thesis that authority becomes meaningful and its power felt only when it is accepted by those on whom it is exercised. Friedrich[12] and Barnard[13] describe authority as a character and quality of communications rather than of persons. Friedrich says that "when we speak of the authority of a person, we are using a shorthand expression to indicate that he possesses the capacity to issue authoritative communications."[14] Seen in the perspective of formal administrative organization, "authority," says Barnard, "involves two aspects: first, the subjective, the personal, the accepting of a communication as authoritative,...and, second, the objective aspect -- the character in the communication by virtue of which it is accepted...."[15] The essence of the definition provided by Barnard seems to be that "authority...lies with the persons to whom it is addressed, and does not reside in 'persons of authority.'"[16] It is the willingness to be influenced, whatever the origin of the willingness, that determines authority as power.

Authority from the law

What are the implications of the above analysis on the worker-client relationship in a social casework setting such as a child protective service? The protective caseworker derives his authority from the law that authorizes the agency to protect neglected and abused children. The power to act is thus embedded in the very nature of the role of the protective caseworker. His authority, however, in terms of legitimate power to act and to influence the behavior of the client in the sense of helping neglectful parents will not find really meaningful expression unless the client accepts this authority. The authority of the agency and the protective caseworker becomes effective with parents only when the neglectful parents yield to their need for help. The acceptance of the authority, then, depends upon the nature of authority as represented by the protective caseworker and as perceived by the neglectful parents.

An analysis of authority factors in protective social casework reveals both socio-legal and psychological aspects. As observed by Studt:

> "Every casework relationship starts with a formal authority relationship. The caseworker is unknown to the client, but is brought together with him by reason of the caseworker's position in an agency to which has been delegated the community's power to help. In each case, and in any social agency, the formal authority relationship must become a relationship of psychological authority if the client is to be helped."[17]

The formal and legal aspects of authority inherent in the role of child protective service remain, but their influence is not so strong as the psychological authority. Studt further observes:

> "It may be said that, in the casework relationship, whenever the psychological aspects of the authority relationship develop strongly, the formal social authority aspects, although still present and effective, become secondary; and the casework process emerges as a particular, highly skilled form of the exercise of influence."[18]

Psychological authority

The concept of psychological authority that is the main plank of the worker-client relationship in social casework has been studied at greater length by Tufts.[19] Fromm's definition of psychological authority "as an interpersonal relation in which one person looks upon another as somebody superior to him,"[20] however, comes nearer to professional authority that is based on the superior knowledge and skills of the worker. The distinction between legal authority and psychological authority is clear-cut — legal authority is a formal power that has been legitimized in the institution structure of the society, but "authority, in its psychological aspects, is an interpersonal relation in which one person (or group) exercises influence over the social behavior of another person (or group) who does not fully accept the reasoning that relates values to actions, but in which both parties know that this influence is being exercised; its intent is known, and hence recognized for what it is."[21]

This leads to an important distinction between "authoritative" and "authoritarian" that seems to be significant for understanding the meaning of authority. The distinction between the two may be based upon their basic purposes. Wasser says: "It is essential to relate the use of authority to the intent, to the purpose of action taken...."[22] Szurek defines an authoritative role as non-coercive authority derived from superior skill and competence for the benefit of the person being helped; this differs from the authoritarian role in which coercive power is used by a person who, for his own ends, seeks to dominate the one being helped.[23]

Rational and irrational authority

The distinction between rational and irrational authority might open up still another aspect of the meaning of authority. Fromm, for instance, distinguishes between the dictatorial irrational authority and the rational authority that has its source in competence. He says that the person who functions competently within authority "need not intimidate...(others) nor arouse their admiration by magic qualities."[24] He further says that "authority not only permits but requires constant scrutiny and criticism."[25] It seems that the ingredients of power and force in authority become less significant in rational authority. Along these lines, Miller says:

> "What I propose is the exercise of rational authority. By rational authority, I mean that which is

> authoritative through reason, not through force or fashion. The teacher ideally represents rational authority...not when he says, 'This is so because I say so (or because everybody says so),' but 'This is so for the following reasons which you may examine.'"[26]

De Schweinitz and De Schweinitz, discussing the place of authority in the protective function of the public welfare agency, make a further distinction between constituted and inherent authority. Constituted authority is an authority of the office and carries a status symbol, but inherent authority emanates from personal qualities of the individual. It is "the authority of experience and learning, leading to judgments which less experienced, less learned persons are willing to follow...without any compulsion to do so."[27]

The implications of the discussion on the concept of authority from an interdisciplinary standpoint for child protective service could be summarized briefly. Authority is a power to act in behalf of neglected children. It carries with it a range of negative feelings for the parents, who may continue to resist as long as they see only one dimension of authority involving the threat and danger of the removal of children. The reaction of parents is likely to be more positive, however, if they can sense the concern of the caseworker and are able to empathize with the caseworker's feelings of respect and his strong impulse to help despite the parents' resistance. The possibility of an unlimited growth potential in terms of enhancement of parental motivation for better child care is increased when the caseworker's authority finds an optimum balance between the agency's expectations and an appreciation of the parents' improvement, though this is often slow. In the ultimate analysis we see that authority as a power of communication has its source of effectiveness in the client and not the caseworker.

Client choice

The issue of authority and choice has fomented a good deal of agitation and critical thinking, since it involves the very basic concept and principle of social casework process. There seems to be a conflict between an authority-based, agency-initiated service and the range of client choice necessary in a growth-inducing experience. Although it is true that the range of choice offered to neglectful parents is limited, and that it does not provide the same range of choice given to a voluntary client in a nonauthoritative social agency setting, there is still some freedom of choice that can be used as a dynamic to release growth potential. Commenting on freedom and authority, Moss states:

> "Throughout the authoritative service, parental freedom is limited in only one way: parents are not free to abuse or neglect their children. The parents have no choice in dealing with the cultural-legal principle of safeguarding children's rights to grow and develop. The parents do, however, have vast freedom. They may choose not to see the agency worker; they may cooperate superficially with the worker, but not change their behavior; they may risk court action with the expectation that their children will remain at home; they may try to improve their children's care."[28]

Inherent in this protective role is one choice that is constant — to be or not to be. The protective caseworker can certainly use this choice as a real dynamic in terms of clarifying to neglectful parents the nature of choice and possible consequences of either of the choices they are prepared to make.

The skill of the social caseworker in an authoritative setting such as child protective service depends on being able to help clients use the limits imposed by agency structure and social demands. As Pray observes:

> "...social casework is the art of helping individuals to find and use satisfying and constructive human relationships, and these relationships always involve a constant adjustment of personal needs and wants to the limits imposed by others and by the social whole. Social caseworkers have to work within those limits, just as the clients must do."[29]

The point that is, therefore, of crucial significance in offering a meaningful choice to neglectful parents lies in the ability of the worker and his disciplined awareness of the professional self. "If caseworkers truly incorporate this concept into themselves as a genuine part of the professional self in helping, then an unrealized potential for helping opens up."[31]

Growth potential

How the use of meaningful choice within the framework of the limits of authority can act as a dynamic in releasing growth potential can be further illustrated with the help of the following case material:

> The Brownlees, a young couple, were referred to the agency because of the neglect of their two children, Annetta, 2 years and Quinn, 4 months. The children

were frequently left without supervision. Quinn, born prematurely, never received medical followup and treatment. The children were ill-clad and appeared dirty and undernourished. At the time the family came to the agency's attention, the father had left the mother and the two babies under the care of the maternal grandmother, who was also a client of the agency.

The mother, mentally limited and too immature to handle the care of two babies, welcomed the agency's intervention as a source of relief. The father, chronically unemployed, vacillated between periods of total dependence and rejection of his responsibility toward the family. Although no evidence of marital conflict was visible, the parents were simply refusing to shoulder responsibility.

The caseworker, holding the mother primarily responsibile for the prevailing neglect of the children, told Mrs. Brownlee that she would either have to take the children for medical examinations, apply for assistance, etc., or face court action. After some initial resistance to authority, the mother began to organize her strength. The baby was examined, and regular appointments at the district health clinic were kept. Her application for assistance was granted, and she moved to a separate household, although with great hesitance about being totally self-dependent. Seeing the change in the family, the father was reunited and, with the help of the caseworker, joined a vocational training program. The caseworker supported the family's progress by exploring community resources for household furniture and surplus food.

In a series of joint and separate interviews the caseworker helped the young couple with budgeting, planning a routine for the children, etc., and thoroughly tested their motivation for handling parental responsibility and also supported them in their growth experience. The case was closed after a year and a half, when the parents demonstrated a greater independence.

The protective caseworker's desire to help must find a spontaneous expression in order to bring about a growth-inducing experience. Very often the worker finds himself in a state of despair, especially when he encounters resistance from the neglecting parents to acceptance of his authority. He is likely to interpret this resistance as defiance and nonacceptance of his inherent and constituted authority. But, if he fails to recognize the struggle within the client himself in finding a place within the client-worker relationship, and if he does not help him yield to his own need as a parent, his authority and role may remain separate. Taft makes a pertinent observation in this context:

> "Basic to a relationship such as this with clients of a protective service, is the caseworker's conviction that her client really wants something better for himself....It takes into account the resistance that can be centered around change....The caseworker knows that it is just this resistance that helps her client to find his own strength. She also knows that the same strength which is used in fighting...authority... can also be used in the rebuilding of relationships that have been broken, and in the creation of a truer balance within the family itself."[32]

Ambivalence

Usually the beginning phase in protective social casework is marked with intense feelings on the part of both the parents and the worker, since the worker has approached the parents when they did not want him. Because they know that he represents "authority," their reaction often tends to be negative and hostile. Even the most skillful and experienced worker often goes through this beginning of the social casework process with neglectful parents with some degree of awkwardness and uncertainty about himself.

The negative feelings might be so intense that the parents may refuse to see the worker, or even when they do cooperate, they may be unable to face the reality of their neglect and the predicament of their children. Although some parents may be so fearful and mistrustful of becoming dependent that they see authority as a power struggle in which they must either capitulate or rebel, other parents may welcome the authority and having the worker take over responsibility for the care of their children. Understanding and accepting these ambivalent feelings of the parents in order to help them resolve these feelings and move toward responsibility for their children is indeed a challenging and rewarding part of the caseworker's job.

It is the strength of authority that burdens and threatens not only the parents but the worker as well. Discussing the inherent feelings of fear about authority in the caseworker, Meyerowitz writes: "He may fear the power it entails and the danger of its misuse, and be resentful towards parent and agency for throwing this burden on him."[33] The struggle of the caseworker in coming to grips with the meaning and use of authority has a built-in danger of overidentification with either positive or negative feelings of authority. For instance, "He may expect parents to be motivated just because he approaches them with authority. He may view authority as the coercive means of controlling parents or accelerating their movement."[34] The protective caseworker can resolve his struggle by conscious understanding of his own feelings and his professional role. Hardman makes a pertinent observation in this context:

> "The degree to which a worker can be helpful to a client with authority conflict is a function of (1) the degree to which the worker understands and accepts his own feelings around authority, and (2) the skill with which he uses his delegated authority."[35]

The basic skills on which the caseworker's authority is based are his internalization of the meaning of authority, his disciplined concern, and his understanding of the social and psychological factors in parenthood. The authority of the caseworker can find meaningful expression in the helping process only when he understands what it means to give help and to take help.

Help from the client

The foregoing discussion may seem to suggest that the caseworker's skillful use of authority is the sole determining factor in the helping process with neglectful parents. There is, however, another dimension that is of crucial significance in deciding to what extent the neglectful parents will use the help. This is, in large measure, dependent upon their perception of the caseworker's authority. The caseworker in the constructive use of his authority must be aware of the limits of his authority as determined by the client's perception. Barnard introduces the term "zone of indifference" to identify the area within which each individual is willing to accept controls without conscious questioning.[36] It seems then if authority is an essential element in the treatment plan, the caseworker's greatest chance of success lies in broadening the client's "zone of indifference" rather than threatening the total relationship through expecting too much of the client before he is ready to accept authority. In this context Mencher observes:

> "Authority is a tenuous phenomenon, and the total casework relationship can be threatened when the worker makes demands that are out of keeping with the client's expectations and that result in the client's denying authority."[37]

Authority as a dynamic

Although authority is necessary in providing protective service to children, it is not sufficient. The dynamic in a protective agency is the skill of the caseworker as he carries his role. His disciplined self-awareness and his understanding and sensitivity toward parents are the bases of an integration of professional helping and agency authority. Authority, it seems, can be a real dynamic in the helping process with neglectful parents only when the protective caseworker recognizes the strengths and limits of his authority and helps the parents yield to their own need to have something better for themselves and for their children.

The following case material is presented to emphasize how authority can act as a dynamic in helping neglectful parents find a new meaning in parenthood under most hopeless and depressing conditions.

> Thomas, a 7-year-old child, was reported to the agency when the school teacher noticed severe burns on his hand. According to the school's information, the father inflicted the burns as a disciplinary measure. Thomas, both physically and mentally retarded, was not toilet trained and appeared uncared for. Investigations revealed parental rejection of the boy. The parents denied physical abuse, but expressed concern about the tremendous problems in handling the child, who often wet his bed, could hardly speak coherently, and was uncontrollable.
>
> In a series of joint interviews, the caseworker explored the feelings of the parents about Thomas and their ability to respond to the child's needs. The father revealed his extreme sense of insecurity and loss of control when Thomas repeated "abnormal behavior." The mother acknowledged that Thomas was not safe and that she would like him to be placed.
>
> The agency finally petitioned the court, requesting the placement of Thomas. Prior to the court hearing, Thomas was sheltered at the agency. Most of his behavioral problems almost disappeared as soon as he left the home environment. The neuropsychiatric examination held at the juvenile court indicated mental retardation, but latent potential for growth under good institutional care. The psychiatric examination of the parents revealed low

intelligence, but lack of any psychosis or mental disturbance. As a result of the court hearing, Thomas was committed to institution placement.

During the time of Thomas' separation from the home, the parents kept regular appointments to see him and were delighted to watch his slow, but steady, physical and emotional growth. Both parents evidently accepted placement of the child as mutually beneficial and involved themselves with plans for the child's future.

The above case is a poignant expression of how authority can be helpful without being coercive and punitive. It is inconceivable that the parents would have accepted the responsibility for their emotional rejection of Thomas and could have participated in this planning of future care without the support of an authority imbued with firmness and respect for parental motivation for change despite the parents' initial rejection of the child.

Conclusion

Authority as an integral part of child protective service has a potential for positive use in helping neglectful parents improve the care of their children. Its effective use, however, depends upon the extent to which the protective caseworker understands the meaning of the authority invested in him. Authority can be viewed as a power of communication and not merely as a springboard of action. The possibility of its effectiveness in reaching out to an unmotivated or resistive client is greater if the caseworker can communicate through empathy and can appreciate the fact that his authority may remain ineffective until the neglectful parents have sensed his genuine concern for themselves and their children.

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[1] See, for instance, the institute on "Authority and Choice in Protective Service," CWLA Eastern Regional Conference, Philadelphia, May 1965.

[2] "Casework and Authority," Editorial Notes, Social Casework, XXXV (1954), 258.

[3] Adapted from Authority as a Dynamic in Casework with Neglectful Parents: Historical and Present Perspectives of the Issue, thesis submitted in partial fulfillment for Advanced Curriculum Certificate (Philadelphia: School of Social Work, University of Pennsylvania, 1964).

[4] "Casework and Authority," loc. cit.

[5] For example, in Pennsylvania the County Institution District Act of 1937 and the County Code Act of 1955 establish the legal base for county responsibility for protective and other child welfare services.

[6] Talcott Parsons, Essays in Sociological Theory (rev. ed; New York: The Free Press of Glencoe, 1954), p. 76.

[7] Harold D. Lasswell and Abraham Kaplan, Power and Society (New Haven, Conn.: Yale University Press, 1950). pp. 131-133.

[8] Ibid., p. 133.

[9] Samuel Mencher, "The Concept of Authority and Social Casework," Casework Papers, 1960 (New York: Family Service Association, 1960), p. 127.

[10] Robert K. Merton, Social Theory and Social Structure (rev. ed.: New York: The Free Press of Glencoe, 1957), p. 419.

[11] W.G. Bennis and N. Berkowitz, M. Affinito, and M. Malone, "Authority, Power and the Ability to Influence," Human Relations, XI, No. 2 (1958), 144.

[12] Carl J. Friedrich, ed., Authority (Cambridge, Mass., Harvard University Press, 1958), pp. 28-48.

[13] Chester I. Barnard, The Functions of the Executive (8th ed.; Cambridge, Mass: Harvard University Press, 1950), p. 172.

[14] Friedrich, op. cit., p. 36.

[15] Barnard, op. cit., p. 163.

[16] Ibid.

[17] Elliot Studt, "An Outline for Study of Social Authority Factors in Casework," Social Casework, XXXV (1954), 233.

[18] Ibid.

[19] Edith M. Tufts, "Psychological Authority: An Operational Definition for Social Work," Social Work Papers, VIII (1961), 1-8.

[20] Erich Fromm, Escape from Freedom (New York: Farrar and Rinehart, 1941), p. 164.

[21] Tufts, op. cit., p. 8.

[22] Edna Wasser, "Responsibility, Self-Determination, and Authority in Casework Protection of Older Persons," Social Casework, XLII (1961), 265.

[23] S.A. Szurek, "Emotional Factors in the Use of Authority," in Ethel L. Ginsburg, ed., Public Health Is People (New York: Commonwealth Fund, 1950), pp. 212-213.

[24] Erich Fromm, Man for Himself -- An Inquiry into the Psychology of Ethics (New York: Holt, Rinehart, and Winston, 1947), p. 9.

[25] Ibid.

[26] Joseph S. Miller, "The Use of Rational Authority in the Adolescent Group," Journal of Jewish Communal Service, XXXII (1956), 272.

[27] Elizabeth and Karl de Schweinitz, "The Place of Authority in the Protective Function of the Public Welfare Agency," Child Welfare, XLIII (1964), 286; reprinted from (Child Welfare League of America) Bulletin, XXV, No. 7 (1946), 1. Quoted from Porter R. Lee, "Changes in Social Thought and Standards Which Affect the Family," in Proceedings of the National Conference of Social Work (Chicago: University of Chicago Press, 1923), p. 289.

[28] Sidney Z. Moss, "Authority -- An Enabling Factor in Casework with Neglectful Parents," Child Welfare, XLII (1963), 387.

[29] Kenneth L. M. Pray, "Casework Paves the Way in Preparation for Freedom," in Social Work in a Revolutionary Age (Philadelphia: University of Pennsylvania Press, 1949), p. 214.

[30] Anita J. Faatz, The Nature of Choice in Casework Process (Chapel Hill: University of North Carolina Press, 1953), p. 53.

[31] Ibid.

[32] Jessie Taft, ed., Counseling and Protective Service as Family Case Work: A Functional Approach (Philadelphia: Pennsylvania School of Social Work, 1946), p. 160.

[33] Hilda Meyerowitz, "Use of Authority in Child Placement," Jewish Social Service Quarterly, XXXI (1955), 328.

[34] Moss, op. cit., p. 390.

[35] Dale G. Hardman, "Authority in Casework -- a Bread-and-Butter Theory," National Probation and Parole Association Journal, V (1959), 253.

[36] Barnard, op. cit., pp. 168-169.

[37] Mencher, op. cit., p. 136.

The Use of Self

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Part I. Theory Informing the Use of Self

Introduction

In exploring the ways in which the social worker can use himself to help his clients, it is essential to study both child development and the characteristics of abusing and neglecting parents.

Theory concerning child development and some specific characteristics of abusing and neglecting parents provide clues to the clients' needs and to the manner in which the social worker can use himself to help meet them. Material on child development helps us to understand children but also parents and what they expect of workers. Material concerning the characteristics of neglecting and abusing parents enables workers to understand what may happen to the children of these parents.

Although each situation is different in many details, there are some commalities. For the purpose of discussion and in order to emphasize the major dynamics involved, we will separate abuse and neglect, although the distinction is not always so clear in practice.

The meaning of behaviors and the implications for treatment

Behavior is a communication about an internal state; it indicates the way the person is attempting to handle or cope with his problem. This behavioral coping may create secondary problems and often masks the major underlying difficulty. For these reasons, it is important that workers learn to view the outward behaviors in terms of the person's internal struggle. Let us consider first the behavioral dynamics of abuse. From earlier presentations you will recall the themes noted repeatedly in studies of abuse situations. In general these include: the presence of a pathological relationship; parental difficulty in coping with their fears and aggression; and a need for help in coping.

Such parents act as though they are in some kind of danger (shades down, unlisted phones) and they are in danger because they are not certain of their controls or ego boundaries.

While these parents often handle many aspects of their lives well, they may fly into murderous rages triggered by a specific type of occurence which is particularly threatening to them. For example, something special may be associated with a particular child: mother dies in child birth; a highly sexualized relationship with the child is being fought off; child does not respect parents; in overt psychosis parents sometimes believe they are "carrying out the Lord's will" or that the child is "no good."

Beating and neglect are attempts on the part of parents to cope with their own feelings. They involve projection and displacement onto the child. Abusive parents are unable to recognize that the problem lies in their own feelings. They have buried any negative feelings about themselves and see the child as powerful--out to expose or "get" them. Coupled with this misperception may be the hidden expectation that the child should gratify the parent's needs. People outside the family see the results of their behaviors and understandably find it difficult to look with compassion on the adult who has harmed a child. But until that adult has help with his feelings and problem, he will be unable to act otherwise.

It is important for us to recall that abusive parents often were emotionally or physically abused children; they feel no succorance, nor do they have anyone to whom to turn. A crisis, real or imagined, triggers a stored up anger linked to an early experience, really a rage which has been simmering beneath the surface with no outlet. Because of this early hurt, he never learned to channel his aggressions. He learned behaviors of lashing out.

This type of parent has a problem in handling any feelings. He cannot be tender and is frightened of anger--hiw own and others--lest it trigger the underlying rage. The following excerpts from a preventive service worker's recording illustrate clearly some of the fears and coping attempts of a mother.

> One is initially struck by Mrs. William's vigor, energy, and seeming stream of words that flow rapidly from her. She literally is at her wit's end with David, a child whom she sees as distinctly different from her other two children and one whom she admits, after some talk, she cannot stand or communicate with; she knows she should do something about it but she doesn't know what. She was very put off by the few minutes she had with Dr. Welch when David was seen at this child guidance clinic for a medication appointment last year and very angry that her descriptions of David's behavior have not been paid attention to.
>
> She said that she feels she is wasting money on the medication, it does no good. David was much better in terms of behavior in school for a while and he was always terrible at home, but two weeks ago the teacher called and told her quite literally that she was wasting her moeny on medication, that David is very disruptive and irritating and acts up in school. Mrs. Williams said David is hyperactive but there is more to it than this; she believes he is not a normal child and she repeatedly came back to this point.
>
> At the time of his birth she felt he was a very aggressive child and described him as literally chewing up her breasts when she tried to nurse him so she did not nurse him and during his infancy he had severe intestinal virus throughout his whole body and this she feels accounts for a possible cause of brain damage and therefore hyperactivity.
>
> David now 9 was two years of age at the time of his parents' initial separation and prior to that time there had been much arguing and physical fighting. At one time her husband had tried to strangle her. There are two other children in the family, ages ten and four. David is the middle child and only boy.
>
> Mrs. Williams has always seen David as different; she says he looks and acts just like her ex-husband but she denies that she sees them in the same light or that she brings her feelings about her ex-husband into her relationship with David.
>
> Repeatedly Mrs. Williams said that her mother tells her often that she has always rejected David, that she never wanted him that she shouldn't treat him the way she does. These comments from the age of two when his hyperactivity was very noticeable as a reaction to his parents' separation. After the death at birth of her third child she was deeply depressed, saying that she didn't even know what day of the week it was, that her husband wouldn't even console her; he acted peculiar. She frequently went to her family physician, who told her to become pregnant immediately and replace the baby she had lost.
>
> David and his stepfather get along well and have what Mrs. Williams termed "good rapport." David likes men, gets along with men generally, dislikes girls and is often assaultive, antagonistic, and irritating to his sisters and his mother. Brenda and David are intense rivals. Brenda is very bright, reads at a seventh grade level although she is only in grade four; David is bright also, but he constantly picks on the baby, pinches her when his mother leaves the room and generally is either set into a role of being a scapegoat or his constant misbehavior causes him to be scapegoated by the family; he is seen as a walking problem wherever he is at home. He was encopretic until six months ago but only at home. He must win or he gets upset; he doesn't get along with kids in the neighborhood; he's a sore loser; he gets "violent" when angry; and he has severe temper tantrums.
>
> Mrs. Williams recognizes her negative relationship with David but I don't think the intensity of it has really hit her yet. She re-

fuses to discipline him because at times she has beaten him and is afraid she will literally kill him if she does physically discipline him. She said as a child her father would punch her when she misbehaved. At one time she couldn't walk as a result of his beating she had to be in bed for a while. This is constantly on her mind. We talked very openly about abuse and she said she keeps her feelings in, walks out of the room, knows if she let herself go she would kill this kid. She is fearful that the younger children will follow David's example and that she simply has to do something. An acquaintance had suggested foster care but said she ought to talk to us first. She said, "I have to get better results from the girls and I do." She speaks of them in a patronizing and sweet way. Mrs. Williams explained at length that she loves children and I would probably think she was crazy after she said she was abusive. She loves being pregnant, she loves having attention, and she loves the physical aspects of delivery. When she found out she was pregnant a fifth time, out of wedlock, by her husband shortly before their marriage, she became panic-strickened, fearing she would have a boy and the boy would be like David. She lost the baby through a natural abortion at three months and this was a relief to her. At present, she and Bill Williams fight frequently about David.

She commented further that she knows she is not a good mother to David but that she feels she is a good mother to her girls. The relationship between herself and David is so hostile that she doesn't know where to begin. She guiltily explained further that she should be able to communicate with him, he is her son, but she can't. She knows at times that she hates him because she feels he has rejected her as a mother but that she should be mature and get over this but she can't.

David's mother is a chronological adult facing the daily tasks of an adult world. People are in various stages of dependency on her; she is expected to be strong, dependable, wise, understanding, and giving. Yet,she is struggling with how to channel her aggressions and with problems of autonomy and selfworth. From your knowledge of human development you are aware that a child needs emotional warmth, consistency, and constant help in defining the parameters of his behavior when about the age of two years, he begins to work toward developing internal controls. Many people reach chronological adulthood without having had the nurturing and security to assist them to accomplish such tasks satisfactorily. They are left with the continuing pressures of insecurity about themselves in a world which makes increasingly complex demands upon them. Emotionally they have some growing to do before they can be fulfilled and fulfilling to others.

Clear treatment implications can be found from the specific behaviors of the abusing or potentially abusing parent when they are viewed in terms of the underlying dynamics. The key to helping is to tune in to the nature of the client's struggle and the coping patterns he has reinforced by use, then to attempt to join him in the process of finding more satisfactory ways of adapting. David's mother is particularly articulate in giving clues as to her needs. All clients do not tell us with words about what upsets them but they do tell us by their actions. It is our responsibility to listen to both and to add our knowledge and perspective to the working alliance. We know, for example, that, regardless of his surface bravado, the abusive parent usually has a poor self-image. This knowledge gives direction to the worker to focus on the parent and attempt to understand him as a hurt and needy person.

Theory tells us that abusing parents' rage is triggered by specific types of crises. With this knowlege and compassion for the parent's fear, the worker and client can attempt to trace the origins of abusive incidents, attempting to identify what triggered the rage. They can examine patterns, and situations which cause tensions. Together the worker and client should get to know preliminary warning signs and consider ways to break the cycle. Through the use of his own concern and agency authority, plus recognition of the client's struggle, the worker may offer the security of external controls while the client develops better internal controls. The worker can help the client to learn to articulate and to channel his feelings. The worker can help the client seek possible channels for sublimation, for relief of tension, and for satisfaction.

The crux of helping, the worker-parent relationship, is a major feeling and learning experience. Through it, the client may find new ways to express and handle anger and feelings in general without fear of damaging the relationship. He may be helped to learn to see things in more subtle shades, to accept the idea of feelings in all relationships, and to give up unrealistic expectations of all love or all hate. The client can be helped to unlearn pathological behaviors. Constraints may be essential; these and other environmental alterations, if utilized on a diagnostic and planned basis are additional tools to aid the parent in channeling his aggressions. Should temporary foster or institutional placement of the child or parent be required, it must be recognized as major surgery. The need for placement is determined from an equation which includes consideration of the controls of the parent(s) and the available external supports. Should placement prove to be the most advisable alternative, it is important that both parents and child receive help in working through the separation. Everyone involved should understand as clearly as possible the plan and the reasons for it.

In contrast to those of abuse, the dynamics of neglect situations suggest more the absense of any intensity of relationship, and the involvement of primarily neurotic characters, frequently possessing impulsive traits. The parent is so infantile emotionally that he cannot meet the child's needs and sees the child as a competitor for narcissistic gratifications. (1) He usually neglects all children because he has little to give of himself.

The neglecting parent's behavior is less specific to a triggering instance than is that of the abusing parent. He often has problems with neighbors, the law, schools; he fails to keep appointments; he is unwilling to open doors; he becomes angry and storms out of offices; he is accused of lacking motivation. Such parents sometimes go through the motions of taking interest in their children, but do not follow through. They are unable to anticipate their children's needs, sense their feelings, or reach out to them. At times it seems to a worker that he is getting someplace with them, and then they become angry, break appointments, or leave saying things are all right.

These parents appear to have many problems, but they really have only one. Their early lives were filled not with psychotic relationships, but with nonnurturing ones. Thus it is the worker's job to act as role model and in a nurturing manner, help these clients toward increasingly more mature functioning. The worker should remember that the results of deprivation are a weak affectional system and a low adult role capability. As illustrated in the *World of Abnormal Rearing Cycle*, cited by Dr. Sherman, these individuals suffer from an absence of trust and an inability to find satisfactory environmental supports. They cannot reach out or give of themselves.

Data concerning neglecting parents often indicates that they were cared for, but not well enough. They still have an emptiness and have suffered a loss. However, the resultant depressison was never acknowledged or worked through because of their youth. These parents have been left with a potential depression, a core of depression, or pre-depression nucleus, and this is the basic source of anxiety with which they must cope. (9) Although they are not conscious of it, relationships with people mean pain and hurt. Since they do not want to be hurt again, they turn and flee from relationships which involve genuine caring. Because they act without thinking when their feelings are involved, they are considered impulsive and unpredictable (11).

The parent who neglects his children is also a chronological adult who must be understood in terms of the level of his emotional maturity before he can be helped to cope more adequately with his feelings and responsibilities. His own nurturing did not push his completion of cause and effect reasoning or of separating comfortably, satiated with parental love and caring(2). Theory suggests that the optimal climate for this growth is one that allows the child to manage the separation process in a healthy manner (7). Hence, in this "hatching" process, the child learns the meaning of security and how to relate to significant others. Should this task not be completed, the child will remain in his own unconnected world. Herein lie the clues for the worker's service to the neglecting parent. Absence or thinness of early nurturing relationships suggests the parents' need for a possible healing process--a safe, caring relationship, but one which encourages developing reasoning and personal responsibility. Yet, formation of a relationship is difficult because these parents have no satisfying prototypes. Therefore, they are constantly testing. Communication is behavioral, not verbal. Such individuals need consistency and persistency, not wooing. They need concern and a caring, restructuring experience. They need help with cause-effect thinking and positive reinforcement when they do reflect before they act or retreat. This type of worker-client relationship harbors many elements of parent-child relationships and, if effective, at first results in some dependency. The worker must then help the client to grow beyond needing him or her as a parental surrogate. The worker can help the client to expand his horizons, develop outer supports and satisfactions while increasing his ability to talk about feelings. The major service to the client lies in assisting him to separate from this satisfying nurturing and develop more mature autonomous functioning. He may then be more likely to give to his own children and not be in competition with them. Homemaking courses, parenting classes, and other task groups are adjunctive effective means for expanding interpersonal interests and developing more realistic expectations of family life.

If emotional growth progresses, these parents may even become able to talk with the worker about their own early disappointments in their parents. If they bring out that sore depression, the worker should help them to work through these feelings. This may be tedious, but the worker's knowledge in recognizing the need and his skill in handling the process are distinguishing features of his profession.

In general, with the neglecting parent, the worker must be accepting and permissive, while serving as a temporary vehicle for the client's dependency. The worker brings with him the security of authority - a safety control. He also brings the potential for a healing relationship, healing because it differs from the inconsistent, withholding and manipulative relationships the client has known. The worker gently wends his way through the barriers which the client has erected against what he has perceived and experienced to be a hostile world.

Part II. The Use of Self

Problems with skill and attitude

The abusive parent needs you to help him develop inner controls. The neglecting parent needs your nurturance. Their behaviors and defences provide clues to their inner struggle.

You are in social work for a variety of reasons, one of which is probably that you thought you would like to work with people rather than things, but some days you question your decision. Also, you certainly like children; that's easy. They have an expectable dependency and there is a tinge in all of us of a need to rescue. However, we should be aware that there is always the danger of focusing on the abused or neglected child and reacting with anger towards the parents. Such action on our part will impede the parents' growth and cause them to experience more of the same feelings of rejection from which they have already suffered so much.

We have mixed feelings about our own competency and hope we make more right than wrong decisions - always carrying in our heads memories of some failures. We expect our caring and efforts to be received as offered. We receive hostility, rejection, constant testing. The need to go over and over the same things as clients struggle (and grow) often upsets our own balance.

Rejection gets to that part of us which has failed; it weakens our self-image. Hostility tends to mobilize hostility in return; it is difficult to refrain from taking these things personally. Constant testing, repetition of the same problems, makes us insecure about whether we are doing the right thing.

We must deal with dependency - a phase in client development that makes demands on our behaviors and reactions. We all have some dependency needs and we may have trouble tolerating anyone taking from us, leaning on us. If we are not totally autonomous or sure of ourselves, we may subtly encourage clients to remain dependent on us longer than necessary, not making use of all opportunities to help them grow to do without us. There are emotional components to this professional relationship that are not entirely controllable by cognition.

We represent authority with our jobs - that of position and of agency. We may have mixed feelings about and uncertainty of the service parameters. When we first begin protective service, we may tend to perceive authority more in the controlling, negative sense than in the sense of helping clients develop their own limits by giving them the security of structure. We may have some residual struggles of our own with authority figures and reject the role, lest we be viewed in the same way we view our nemesis.

We always wish we had more self awareness. We all have an Achilles Heel and tend to miss things related to our "blind spots," i.e. once a relationship to parents is established, workers run the risk of overidentification and hence may minimize the client's worry about his impulse control. If we fear anger, we might miss some clues to the client's rage. Most of us do have problems with anger and tend to shy away from any emotionally-laden material. Our clients have rage, terrifically potent rage. If our habit is shying away, not hearing, and we are unaware of this pattern, we lessen our helping potential.

Neglecting and abusing families have many problems in the sexual area. As theory suggests, they are emotional children and have difficulty channeling feelings and drives. Adult sexual capability becomes a powerful force. Our moral or religious values may get in the way of our seeing their behaviors in context and our own sexual insecurities may cause us to avoid helping them deal with their sexual behavioral problems.

We have varying degrees of empathic capacity (usually lower at the end of the day or week); we often miss non-spoken messages or pleas, and tend to take things at face value. When we fail to pick up clues and feelings, the client perceives us as not understanding him or not being any stronger than he is. He cannot trust us as someone on whom to lean.

And above all, we rarely realize what a tremendous impact our intrusion into their lives and development of a caring relationship has on people. It provides another in a lifelong series of episodes which has the potential to hurt or sear and reinforce the pathology it was meant to correct, *or* it might be a different and healing experience. As we learned from theory, there is always an unspoken hope in the client for someone to understand him, coupled with the fear that he will be failed again. Our own anxieties are often triggered by the intensity of many of the situations with which we work. Under such circumstances, we have a tendency to talk rather than to listen sensitively to the many levels of communication from our clients (4).

We need practice to consider the defenses (projection, denial, isolation), which anger us so, as helping the client keep his balance. He needs them; we cannot rob him of these things which hold him together. We can use them as his communication about the intensity of what he fears, that is, we can use them diagnostically. When he is stronger, he will need them less. He alone can give them up, we cannot take them away. We need to measure progress in small increments, that is, one decision by a client, one think-before-acting incident, etc. We should form the habit of constantly assessing our own meaning to the client. How does he view us? Does he view us as helping? Caring? Punishing? What part of his former world do we represent?

A process to assist in developing empathy and in organizing data to enhance understanding

When you first meet a client, you begin to learn about him and attempt to understand him and his situation by clues from many sources. You consider:

a) facts about him - age, sex, where he lives, with whom, etc.; also, the problem - how it is now and maybe how it was in the past; what changes there have been

b) what you see and hear from him directly

c) what you know about people in general - their needs, stresses, tolerance, etc., i.e., you draw upon theoretical knowledge

d) practice wisdom - your experience with similar kinds of people and situations; what you have picked up from working with people, but not necessarily consciously translated into theoretical knowledge

e) you own inner feelings and reactions

You develop a mental picture of the client and the situation. With these data, and from this picture (diagnosis), you begin to develop a plan to help (intervene, treat).

A major problem with neglecting and abusing parents, is that our fears and anger loom large in our inner feelings and frequently preclude our sensitivity to the client's hurts and suffering. Our sympathy gets turned off, and we unconsciously lose or distort some potentially valuable data.

Prior to this session, you were asked to write some notes concerning a client you have found difficult to understand. Together, with each of you using the information about your own client, we will go through a series of guided steps trying to capture and organize data important to developing a diagnostic impression. The material is for your use and will not be collected; we will discuss the reasons for each item following the exercise.

See Appendix A

Discussion

As you responded to the questions on the exercise you have just completed, you were building a "dynamic mental representation," a working model to which you added and from which you continually drew in thinking about your client. Your model was made up of "knowledge" from four sources:

1. the individual himself as he is in the present and was in the past
2. those environmental forces which have served and are serving to influence him and shape his destiny
3. theoretical knowledge, practice experience, and practice wisdom
4. experience with similar kinds of situations, real or fantasied

You were guided to consider the dimensions of your client's world by:

a. present circumstances where and with whom he lives, under what conditions, and with what quality of family relationships

b. means of livelihood and attitude toward these; if dependent, his feelings about dependency

c. most meaningful relationships - past and present; current patterns of relating to peers and others, particularly to persons in authority or potential authority over him or to persons over whom he has authority

d. early life experiences which may illuminate present difficulties

e. current problems and what concerns him most about them

f. his ways of keeping balance, of keeping himself together, of defending himself

g. what he wants and how much he wants it

h. how his social environment may enhance or limit his opportunity to accomplish his objectives and

i. his potential as he and others close to him understand it

You were being asked to utilize your knowledge, memory, and experience in a manner which laid down in your mental image of the client information which accumulated and further specified the complexity and individuality of your client as you proceeded. The juxtaposition of the tasks and their order were designed to effect additional, less obvious, dimensions of your understanding. You were being guided to invest much of yourself, your feelings, in further developing empathy for your client.

Theorists (8,10) suggest that empathy, or "feeling with," adds highly significant data to the mental image we build and from which we draw in working with our clients. Theorists also believe that empathic understanding can be developed and several experiments have corroborated their hypotheses (6,8). Hence, in addition to the tasks of recall, the exercise guided you through phases of mental and emotional response calculated to add effective data to your mental representation of the client. These phases have been termed: identification, incorporation, reverberation, and detachment (8). Specifically, the process building toward identification directed your attention,to moving back and forth between factual data and the meaning to your client of the feeling elements of old and new experiences. The mixture of fact and feeling elements seek to preclude very empathic workers from yielding to sympathy. The tasks aimed toward the phase of incorporation sought to stimulate your imagination to feel your client's problems as if they were your own. In requesting that you attempt to evoke some of your own life experiences which might have had similar affective components, the exercise design sought to engage you in the phase of reverberation. Questions and tasks which demanded your objective analysis of the data were geared toward sufficient detachment from the enlarged image of your client to aid in your planning short and long term practice goals.

In your daily work you have automatically or intuitively gone through many of these steps during your assessment process. We have engaged in this exercise in concert and a discussion of the rationale for the process merely in an attempt to offer you a consciously held tool for organizing the plethora of behavioral dynamics and the wide range of your personal responses involved in working in protective services.

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Appendix

Exercise
Session on Use of Self

Directions

1. Put aside your written material.
2. Reflect for a moment on what you know about your client.
3. We will work together on the questionnaire one page at a time. I will tell you when to turn the page. It is important to concentrate only on the task at hand, one task at a time. If some of the facts called for have escaped you, do not devote much time in the attempt to recall them. It is more important that you concentrate on formulating your impressions.

1. Following your first meeting with a new client, your understanding of him/her as a real person is more or less clear depending upon many factors. The line below has two end positions or extremes. Consider your impressions of the client you described in your paper and place a vertical mark at any position on the continuum which best conveys how you understood your client.

I understand the inner and outer stresses on my client and feel comfortable with my assignment to help him/her.

I find it hard to understand my client or to imagine if or where he/she is "hurting" or suffering.

2a. With whom did your client live at the time of your meeting?

2b. Did he/she feel comfortable there?

2c. If comfortable--for what reasons?
If uncomfortable--for what reasons?

3a. What were your client's physical living arrangements?

3b. Was he/she content with the arrangements?

3c. For what reasons do you believe your client felt as he/she did about the living arrangements?

4a. What was your client's employment status?

4b. Had there been a recent change in his/her employment?

4c. How did your client feel about his/her employment or means of support?

5a. What hobbies, interests, recreation, diversions, other activities did your client have?

5b. With a word or phrase note the quality of your client's investment in socializations, diversions, etc.:

early life (if known)

currently (time of interview)

6a. List persons meaningful to your client in past and present life..

6b. Note with a phrase or word how your client felt or feels toward each.

7. Note with brief phrases some things your client recalled about his life prior to the time you talked with him/her. Note what he/she volunteered and what he gave in response to your probing.

a. Things recalled	b. Volunteered	Result of Probing

7c. What do you believe is the significance of the difference in the type of material he/she shared volunatrily and that which he/she was asked to share?

8a. What was the behavior or problem for which your client was referred at the time you saw him/her?

8b. Was the situation/condition/problem a long standing one?

8c. What do you believe precipitated the current acute stage or referral?

9a. What about your client's present situation concerns him/her most?

9b. What did your client want from you?

9c. Note opposite each item how he communicated his/her desire= to you.

10a. At the end of your first interview was your client able to engage with you in discussing how you both might work on his/her problem/ situation?

10b. If so why; if not, why?

11. According to our understanding of human behavior, people develop characteristic ways of dealing with feelings which bother them. From your client's symptoms, behaviors, way of life, and current state, what do you believe are some of your client's underlying feelings?

12a. As you became acquainted with your client through seeing and talking with him/her, what emotions were evoked in you?

12b. To what theme in your client's communication would you attribute your emotions?

13. For a moment, try to imagine that *you are your client* at the time you saw him. In this capacity what are some of the words or phrases you feel like using to describe yourself and your general life situation?

14. Write down what you think are your client's strengths, his/her potential.

15. Your client may remind you in some ways of individuals you have known personally, seen as clients, read about in literature, seen on theatre, stage, or screen. Without using names, indicate below:

a. Sex and approximate age of such persons	b. Basis for your knowledge	c. What characteristics your client and the person designated appear to share

16. After this exercise in thinking about and trying to feel with your client, he/she may have become to you more or less understandable or vivid as a person depending upon many factors. Consider your own response, as of this moment, and place a vertical mark at any position on the continuum which best conveys your estimate of your understanding.

I understand the inner and outer stresses on my client and feel comfortable with my assignment to help him/her.	I find it hard to understand my client or to imagine if or where he/she is "hurting" or suffering.

The Assessment and Counseling of Abusive and Neglecting Parents

A theoretical framework

Dysfunctions of Parenting: The Battered Child, the Neglected Child, the Exploited Child

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Introduction

The normal purpose of parenting is the conception, birth and culture of children through a confluence of drives which subserves the perpetuation of the species by the creation of a new individual. A parent must stay alive and sane to attain this goal in any part. Self-preservation commands an obligatory priority in the parent's distribution and utilization of his psychic energies and culture of the child is subordinated to the parent's requirements.

The battered child and the neglected child and the exploited child each represent a by-product of the parent's particular pattern of mental manoeuvring to maintain homeostasis in face of an emergent threat to his own psychological integrity.

Culture of children confronts the parent with all of his aspirations for the future and taps into all his emotions from the past. The mere presence of the child serves to activate in the parent any latent conflict between what he is and what he wanted to be, between those emotions he has felt and those emotions he has been unable to accept. Being a parent to a child mobilizes the child in the parent and forces claim that each recognize and acknowledge the other. When this meeting occasions such conflict that open strife ensues, the resultant tension may be discharged on to the child.

The closeness of the child to the parent allows for its use as a means of relief from distress. The fact that the child is derived from the physical substance of the parent makes it eminently suitable for utilization as an extension of the parent's psychological substance. The way in which the child is utilized to afford relief to the parent depends upon a complex of factors. The age, sex, and birth order of the child are important in dictating the corresponding times and issues in the parent's past. The parent's character structure determines the type of behaviour he will bring to bear upon the child in response to his perception of the child and the emotions it evokes. Depending upon the interplay of these forces in their particular cultural context, the battered child, the neglected child or the exploited child will appear as the result of a dysfunction of parenting in which the perpetuation of the species has been sacrificed in some measure to preserve the integrity of the individual.

The battered child

Definition

The battered child has been physically abused by an adult without provocation in the child's behaviour. The child is usually too young to be considered capable of conscious deliberate acts or of the use of language as an organized mode of communication which distinguishes the syndrome from punishment.

Description

A little boy or girl is brought to attention in a state of morbidity varying from terminal coma to relative health. The combination of fresh and old bruises, recent and healed fractures of the ribs, head of the humerus or the skull with welts or burns are pathognomonic of repeated trauma. The parents may or may not acknowledge their responsibility. Usually their initial story is vague and subject to later revisions. The child may or may not show evidence of neglect. Many of these children are well nourished and dressed.

The acute picture is of two sorts. One is of listlessness, apathy and unresponsiveness to all but painful stimuli. The child displays a blunting of all evidence of vitality akin to that seen in adult cases of shell shock. It appears that the child has attempted to fend off further assault by suspending any signs of physical and psychological animation and feigning death. The other pattern is characterized by flight in fear upon any approach. The child cowers, whimpers and attempts to hide from attempts at contact.

From Galdston, R., "Dysfunctions of Parenting: The Battered Child, The Neglected Child, The Exploited Child," in Howells, J.G. (Ed.), Modern Perspectives of International Child Psychiatry, Edinburgh: Oliver & Boyd; New York: Brunner/Mazel, 1968. Reprinted by permission of the editor.

With time and treatment the picture changes as the child follows one of four recognizable courses.

(i) Death either with or without demonstrable physiologic cause.

(ii) Clinging without discrimination to any and all persons who avail themselves to the child.

(iii) Recovery from the sequelae of physical abuse with persistent signs of anxiety and withdrawal at the approach of others.

(iv) Recovery from the stigmata of physical abuse and rapid growth of ego skills far beyond the pre-morbid level.

Signs of pleasure in eating are the harbinger of the return of an investment in living. The gradual introduction of persons who respond to the child in accordance with its level of being fosters the accrual of bits and fragments of pleasure which in turn promotes a shift from inertness towards an attitude of activity. Preserving a climate of care which accommodates to the developing initiative of the child allows for the further flourishing of pleasure which in turn promotes a shift from inertness towards an attitude of activity. Preserving a climate of care which accommodates to the developing initiative of the child allows for the further flourishing of pleasure which is often accompanied by a temporary renunciation of a specific skill. A beaten, debilitated 3-year-old who fed herself with knife and fork and fastidious joylessness upon admission to the hospital responded to treatment by forsaking implements in favour of exuberant finger feeding. Only by turning back the clock of ego development through temporary regression in its skills can the lost pleasures be recaptured and wedged back into the nooks and crannies of experience. It is a regression in the service of the growth of the ego.

Under proper treatment some of these children can make remarkable recovery to levels which appear to exceed their previous maturity. However there are points of no return. It appears that the age of 3 1/2 to 4 mark the point of closure beyond which the ego has great difficulty in utilizing pleasure to correct previous damage to its development.

It is noteworthy that observations of over 100 battered children have failed to detect a single instance of autistic development or childhood schizophrenia although many of the children display periods of auto-erotic activity during their recovery phase.

Parents

There are seven factors which collectively dispose parents to resort to beating a child in order to spare themselves the conscious experience of their own intrapsychic distress. No single element is unique to this syndrome nor will any one alone account for the phenomenon. The presence of each of these items increases the likelihood that a parent will batter a child.

(i) Major reliance upon projection as a leading defence against intrapsychic stress:

Clinically this feature is illustrated in the choice of terms used to describe the child. The parent speaks of the child in words appropriate to an adult. Whereas the normal parents on occasion will speak of the child 'as if' he were an adult reflecting the human tendency to project ourselves into our offspring and the present into the future, these parents omit the 'as if' and confuse the child with the adult. There is a defect in their capacity to test the reality of the child. The child functions as a delusion in what is essentially a transference psychosis.

(ii) A tendency to translate affect states into physical activity without the intervention of conscious thought:

This impulsivity enables the parent to 'take it out on the child'. The act of 'taking' conveys the literal transfer of affects from the parent on to the child.

(iii) The presence of intolerable self-hatred:

This is the 'it' which the parent 'takes out' on the child. The qualities and attributes with which the parent endows the child and for which he abuses it are the very features which he cannot countenance in himself. They are expressions of that affective residue of his life experience which he cannot tolerate acknowledging as his own. He tries to dispose of them by projecting them on to the child and exorcizing them through physical abuse. The child is the scapegoat for the parent's unconscious sense of self-loathing.

(iv) Correspondence of the child by sex, age and position in the family to events in the parent's own life which occasioned his great self-hatred:

The capacity to see ourselves in our children is influenced by the extent to which the child's physical presence in time and place correspond to our own affects. A parent who despises his own dependent longings is more likely to beat a young infant. The parent who cannot tolerate his sexual feelings is more likely to abuse an older child. It is the presence of the child of a particular sex, age and position which serves as the seed crystal about which the parent's forgotten unwanted emotions threaten to precipitate out of unconsciousness into painful awareness.

(v) Relative lack of available alternative modes of defence against conflict because of environmental factors:

Poverty, illness, domestic demands, social isolation, housing problems all can contribute an increment to the likelihood of physical abuse by reducing the availability of alternative modes for discharging intrapsychic tension.

(vi) Compliance with the act of beating by the marriage partner due to dependence and a reciprocal willingness to support projective defences:

The scapegoating phenomenon has considerable power to recruit unconscious collusion among those for whom dependent needs with their attendant guilt have a high priority. Passive compliance spares the partner from the anxiety which would accrue from active intervention.

(vii) Relative absence of available authority figures:

The deterrent power of grandparents, religious or social authorities as an antidote to idiosyncratic perceptions and eccentric behaviour is seldom available to the abusing parent. In many cases the parents previously have sought out the influence of such figures without obtaining their response.

In addition to these seven genetic factors there are three noteworthy corollaries.

The reversal of marital roles among the abusing parents is usually gross and long antedates the child. The outbreak of beating often coincides with a breakdown in the role reversal because of external factors. This illustrates the defensive function of role reversal in sparing the parent from the intrapsychic conflict mobilized by the presence of the child.

Jealousy of the child, a common parental affliction, is not a force for beating. Its presence bespeaks the parent's recognition of the child as a separate, albeit more favoured, person. Jealousy of a child is a force for spouse abuse not child abuse.

Neglect and beating the child may or may not coexist. If they do, the course is one in which the parent has attempted to neglect the child without success. Because of the ambivalent quality of the parent's attachment to the child he cannot give it up through neglect and is forced to recognize it in abuse. The parent who beats a child is not the parent who abandons it and few are willing to give the child up for adoption. These are highly wanted children whose existence fulfils a complex of parental needs. Such is the nature of human attachment to children that intense, contradictory and very personal emotions can follow rapidly one after the other. When the child is out of the home these needs are not fulfilled and the missing child is often sorely wanted. When the child is gone the guilt is gone leaving only a longing.

The neglected child

Definition

The neglected child has not received sufficient attention from his parents to promote growth. His requirements for stimulation have not been met and his development has suffered with resultant retardation in physical and psychological maturation.

The neglected child lives with and is neglected by his parents. His plight differs from that of the deprived child who has been deprived of his parents and is therefore free to forage for the attention of others. The neglected child lives in the solitude of a family prison.

Description

When the condition is marked the neglected child presents as one who has failed to thrive. Below the range of normal percentiles for height and weight he appears emaciated, uninterested in his surroundings and devoid of any but the simplest self-centred activity.

Usually the history is one of fussy eating habits with poor food intake and frequent regurgitation. Often the stigmata of chronic malnutrition are present despite the parent's assurances that adequate amounts of food have been presented to the child. He is not lying. His perceptual grasp of his child is so feeble that both the flesh of his body and the stuff that goes to nourish it lie beyond his ken.

When asked, the parents describe the stools as very foul-smelling, but upon being questioned further they portray most of the child's physical attributes as offensive. A history of chronic diarrhoea is common. A prior diagnosis of coeliac disease or intestinal allergy may have been entertained.

The characteristic feature of the neglected child is his lack of spontaneous activity. The child sits and does nothing. He gives no sign of curiosity, fear, pleasure, or pain. The blank facies, fixed posture, and stilled voice lend him the semblance of a miniature mummy. Usually these children fall between the ages of 3 to 24 months, but they are so much smaller than their chronological age would warrant that the observer may fail to appreciate the peculiarities of behaviour because he views the child as being younger than he actually is.

When left to his own devices the child sits inertly failing to manipulate proffered toys, ignoring the initial approaches of others while rocking, picking at small spots on his skin or the bedding, or humming to himself. Yet the child recognizes other humans, follows them with his eyes and appears quite aware of the persons and events about him. Passive, alert and joyless the neglected child is a psychobiological robot. Neither happy nor sad, without fear or fun, he is and no more. Existence is a matter of physiologic function for the neglected child and no part or process of his body has been surcharged with emotion. Sucking, mouthing, touching, defecating, smearing, seeing and all other vital activities are performed without pleasure or pain. Venepuncture can often be accomplished without protest.

On initial observation the neglected child appears incapable of the motor skills appropriate to his chronological age. With repeated encouragement the child reveals his ability to perform the act in a mechanical fashion. Herein is the rub of his pathology: a primary failure to fuse feelings with his body. Neither eating nor patty-cake, nor piling blocks nor beek-a-boo provide the child with pleasure. There is no joy in doing anything. There is no gratification in any part of his body. Most children respond with uncontrollable giggling when the observer pokes his forefinger to tickle the belly-button while sticking out his tongue to make a flatulent sound. The neglected child stares in disbelief. The constituent parts of his body with their associated processes and derived functions fail to provide him with pleasure. Their exercise is a matter of automatic necessity commensurate with staying alive. The child fails to thrive because there is nothing in it for him, neither pleasure nor pain.

The treatment of the neglected child requires the provision of stimulation diluted to a consistency which the child can tolerate. Starting with a gruel of mere bodily presence and gradually adding in playing with a shared object, the concentration of stimulation is titrated to the level of the child's current capacity to absorb attention.

The initial absence of appetite for food or contact can be a discouragement for those charged with caring for the neglected child. It requires that the person who proffers herself to the child be comfortable in the face of rejection. She must be able to accept the child's ignoring her even as the child has been ignored. Gradually there follows an activation of appetite for food and for stimulation. Once mobilized, the craving passes from the tentative to the voracious. It is as if a back-log of longing once released, pours forth. The child consumes an enormous amount of food and comes to cling tenaciously and indiscriminately to anyone available. His newly developed activity is awkward and often offensive, poking in the ears and up the nostrils, pulling the hair and besmearing the person who cares. This shift from passivity towards activity may pose a strain on those who are comfortable with an inert passive child but not with an intrusive messy one.

The provision of adequate appropriate stimulation adjusted to the child's changing capacity to receive attention is as specific a therapy for the neglected child as antibiotics are for the child with pneumonia.

The act of feeding is the basis of everything. The pleasure of the one who feeds becomes the child's pleasure. The affect goes with the foodstuff. No bottle-propping, naso-gastric tube feeding or intravenous drip can provide this crucial ingredient which cannot be synthetic. Around feeding, comes holding and touching and seeing. His arms, hands, and eyes become something of value to the child and their exercise becomes a source of pleasure to him in response to the one who takes pleasure in his presence.

If treatment is begun by the age of 24-30 months the neglected child can make great strides in development. Many aspects of the failure to thrive can be overcome with the restoration of normal levels of physical and motor maturity. The child can learn to acquire pleasure from the exercise of many ego skills. However, there is one area of operation which is particularly vulnerable to irreversible destruction. The establishment of a hierarchy of relationships with the dominance of a one-to-one attachment which is characteristic of the healthy child and his mother proves to be beyond the capacity of most of these children. They retain a promiscuous attitude towards all persons utilizing them without regard for their individuality. It is as though the absence and presence of pleasure have been such consuming issues in their early experience that they are left incapable of perceiving beyond the sensory state to recognize the person behind it. It is not pain which causes this failure but rather the absence of pleasure. Observations of children in acute or prolonged pain from accidents or illness indicate that pain, like pleasure, is a sensory state which occasions affects which the child can share with others to sustain a sense of self.

Parents

Parents who neglect a child can be considered in two groups. Those who rely upon projection as a leading defence against intrapsychic distress perceive the child as belonging to them but see it as the embodiment of undesirable attributes. The second group rely heavily upon denial as a defence against intrapsychic distress and they suffer from a primary failure to perceive the child as belonging to them.

The first group of parents share many of the psychological features of the parent of the battered child. However, they do not have the same tendency to translate affect states into physical activity. They are not impulsive. They are compulsive. They are disposed to utilize mental mechanisms to abuse the child and defend against this disposition by putting as much distance between themselves and the child as possible. Such a parent sees his child as bearing the loathsome qualities for which he despises himself. To avoid beating it he relegates its care to others. Herein socio-economic factors play a significant role and account for the apparently greater incidence of the battered child among the poor. The poor cannot hire others to care for their children. If there is an effective extended family they can get someone else to care for it. Otherwise the poor parent is forced into intimate contact with the child he sees as hateful. The well-to-do parent can seek relief by putting physical distance between himself and the child through the use of a nursemaid.

Similarly the presence of authority figures serves as a powerful deterrent against physical beating and tends to reinforce the reliance upon neglect of the child as an alternative mode of relief. In general, society is more tolerant of sins of omission than of sins of commission. Among those instances where the child has first been neglected and then beaten, the loss of a babysitter or the money to hire one, or the loss of a previously available authority figure often precipitates the outbreak of physical beating.

The second group of parents deny the existence of the child. They fail to perceive the child as theirs. They account for those children afflicted with early, severe failure to thrive requiring hospitalization within the first six months of life. Such a mother gives eloquent testimony of her need to deny that the child belongs to her. She says that she had great difficulty in finding a name for the child until it was several weeks of age and then gave it a name chosen by someone else. She may tell of a fantasy that the child is a changeling foisted upon her in the hospital. Complaints that she was never able to 'feel for the child' are common, as are statements that the baby ignores her and isn't interested in the food she has to offer. Often the mother asserts that she noted nothing wrong with the infant and was surprised at the shock expressed by a relative or physician at her child's cachetic state. Only when the child is taken out of her charge and institutionalized as the proper responsibility of others is she able to perceive it in its being.

Such a mother is self-centred by definition. Her sphere of perception is so restricted that it cannot accommodate her child of whom she disposes through denial. Yet in other areas of her life she may well be able to extend her awareness to include others.

It is her knowledge of the very existence of the child which is denied rather than some specific attribute which she perceives in the child. It is not what he is, but rather that he is which the mother cannot stand knowing. This mother is highly vulnerable to post-partum depression of psychotic proportions. Knowledge of the existence of her child would fill her with an unbearable sense of unworthiness. She spares herself this burden by denying the existence of the child who in turn fails to thrive. For such a mother the existence of the particular child is a fulfilment of wishes which she has rejected as inadmissible. The reasons for her having reached such a conclusion are deeply rooted in her past and dwell beyond her range of conscious access. As long as the mother harbours her prohibition of this conception she remains vulnerable to severe depression or the child will fail to thrive as a result of obligatory neglect. These mothers, when forced by external circumstances to lay claim to the child as actually belonging to them, are prone to suicide and infanticide.

The exploited child

Definition

The exploited child lives in a state of partial symbiosis with a parent for whom he provides a specific intrapsychic function which they share. His performance of a particular psychological service for the parent is the basis of his primary value for both parent and child. All other aspects of the child's being are subordinated in their claim upon energies for development. The exploited child functions as a pseudopod extending the parent's psychic structure to fulfil a task specialized in accordance with a pre-existing failure in the parent's personal development.

Maturation demands the sequential mastery of developmental tasks each of which involves the resolution of appetites with their corresponding expectations for behaviour. A state of inner conflict will persist if the parent has been unable to bring about a harmonious fusion of his desires and his performance. Under certain circumstances the parent may seek relief by exploiting a particular child as the repository for one of the constituents of his own conflict. The child is made the agent of an appetite or the standard bearer of a prohibition. In either instance he functions as a prosthetic device for the adult. The exploited child has been sent upon a man's mission.

Description

The hallmark of the exploited child is stamped in some aspect of his appearance as a caricature of adulthood. In word, gesture, facies, posture or deed the exploited child conveys his efforts to perform a psychological function suited to an adult. Overall the child does not act his age. His demeanour and countenance may appear to be older or younger than his years but some feature of his being will have the mark of adulthood. This behaviour, this function and this part of his body are strained with the burden of the precocious fulfilment of a requirement for adulthood.

Other aspects of the child's being have suffered a reciprocal inhibition in their development. Attitudes, interests and behaviour appropriate to the child's actual years are missing having been abandoned by the wayside in favour of the adult function in which the child has specialized.

When the charge of his own minimal needs plus the surtax imposed by the parental assignment exceed his capacity the child is liable to break down in certain recognizable fashion. The presenting symptoms and signs to which the exploited child is particularly vulnerable are influenced by the function and the organ which have been stressed with the burden of adult assignment. These can be classified in terms of the desires served and/or the prohibitions enforced.

Certain cases of childhood obesity are due to the exploitation of the child's feeding to satiate the parent's appetite. The adult's eyes are bigger than the child's stomach. These children are enormous. They eat all the time without knowing why. They deny any pleasure in eating. They have no likes or dislikes or any food fads. They eat automatically without gusto or discrimination. They have been fed incessantly like a stuffed Strasbourg goose. Yet when removed from their homes they welcome dieting and weight loss which is usually reversed upon return.

Some children do not master control of their bowel function and persist in defecating when and where they do. Often the history is of sparse and short-lived efforts by the parent to train the child with eccentric practices such as spreading newspapers about the house or rubbing the child's face in his feces. The parental attentions to the child's fecal functions are less in the service of the mastery of continence and more to obtain vicarious freedom from the fetters of self-control through the perpetuation of the child's messiness.

Certain children display a precocious air of interest in sexual intercourse. In word or posture, act or suggestion they invite adult attention towards their genitalia. Many of these children have been directly stimulated by a parent or knowingly have been exposed to the sexual attentions of another adult.

Certain children display disordered behaviour characterized by their repeated involvement in accidents from which they suffer fractures, burns and lacerations. The activities in which they are hurt are appropriate to a much older person. Study of the circumstances of the accident often reveals that the parent had directly invited the child to participate in an act which served to gratify the parent's own desires for violence. The child describes the event in the vernacular of an adult as if he viewed the act as quite consistent with his station. The desires served are as much or more the parent's than the child's. It is not merely that the parent fails to declare a prohibition but rather he issues an invitation to the child to partake of a particular bodily activity.

Conversely there are children who are exploited to subserve a parental need to erect prohibitions against their own instinctual cravings. Many children obtain precocious impeccable control of their bodies. They regulate their mouths, their eyes, their limbs and their sphincters as if their very lives depended upon it. They believe that they do. This performance is not merely to please the parent. It is based upon their appreciation that the parent's psychic integrity and with it their own protection depend upon their sparing the parent from the threat of loosely regulated appetites.

There are children who inhibit their intake of food to the point of weight loss. They have concluded that the food is bad or that the act of eating is bad or that they themselves are bad. The attendant self-deprivation roots out a major source of human pleasure. Often study reveals that the parent had directly asked the child to support efforts at restriction of food because of his own difficulty in mastering the intensity of his appetites.

There are certain children who have imposed such complete prohibition upon the relaxation of their anal sphincters that they develop severe constipation. They pass days without moving their bowels save for overflow incontinence. Usually these children were subjected to early and desperate toilet training that bespoke their parent's anxiety about the act of defecation and whatever pleasures they associated with it.

Certain children, particularly girls, are subject to disorders of urination characterized by burning and frequency without evidence of infection. They occasionally wet themselves during the day but not at night. They go to the toilet many times a day and always need to know its location. These children charge the control of urination with great concern. Their urethral sensations serve to remind them of the threat posed to them by the loss of control.

Some children pass through childhood and adolescence without showing any awareness of their genitalia. They do not touch, fondle or display. They do not masturbate. They behave as if the world were asexual and they had neither genitalia nor erotic sensations. With the advent of pubescence these children are vulnerable to the development of headaches which become preoccupying and a cause for severe restriction in their social intercourse. Often these children come from homes in which sexuality in all its dimensions was denied. The child responds to the parent's stand that the existence of the genitals and their sensations is too dangerous to recognize and he protects that position.

There are certain children whose early attempts to discharge energy through the exercise of their musculature upon their parents failed to elicit a response. It takes two to play patty-cake. These children often grow awkward, inhibited, and passive in their attitude towards the energies of aggression.

Regardless of the appetites served or the standard carried the exploited child has the cast of asymmetry to his development. He is a psychological specialist trained to perform one particular function at the expense of others. He is old in one respect and young in others.

The differential diagnosis of the exploited child lies with the child who has identified with an adult or the child who spontaneously has grown in an asymmetric fashion. The diagnosis is based upon the failure of the exploited child to derive pleasure from the exercise of his skill. Whatever the instinct expressed or the prohibition maintained the child works for the adult. His behaviour aims at the parent's relief and it takes its power from the urgency of that need. The exploited child may derive pride in the exercise of his function but not pleasure. His behaviour is not harnessed to his appetites or his expectations. He is in life's business for another. The nature of his actions is determined by the dictates of his parent's needs rather than taking source from the initiative of his own identifications. His performance is prescribed as obligatory in the priority of prerequisites for parentage.

Parents

Exploitation of a child by his parent is a process of which neither is conscious. The main purpose of exploitation is to spare the parent from conscious knowledge of one element of his intra-psychic conflict, either an appetite or its prohibition. The attainment of this goal requires that neither parent nor child know what they are doing. The resultant motivational vacuum is filled with rationalizations which constitute a contract in which the child and parent agree to exchange psychic service for upbringing. The pact comprises statements describing a relationship. Behind the manifest text is a secret treaty honoured in a private world. The covert clauses are written in the special syntax of a parent speaking to the child as if he were also the parent. Enforcement of the contract is implemented through the threat of abandonment by the parent and betrayal by the child.

The translation of such terms into their unconscious meaning requires the observer to note the words, the way they are spoken, the physical placement of the parent and child, intonation, gesture and what goes unsaid. It is as much how it is done as it is what is done. The mother says to the physician of her incontinent 6-year-old son, 'We are having trouble with our bowel movements, doctor!' She means 'His bowels are my bowels!'

The father says of his exhibitionistic 10-year-old daughter, 'I'm afraid she doesn't like psychiatrists, doctor. She doesn't like to make trouble!' He means, 'I don't want a psychiatrist to confront me with my incestuous longings for her'.

The parent says of the child, 'I can read her mind and she thinks just as I do!' He means, 'I will do all the talking for her and don't you talk to the child nor the child to you!'

The parent says to the child, 'All of us Smiths think so and act this way and do that!' He means, 'If you want to remain a member of the Smith family you had better do and be as I tell you!'

The father says to the daughter, 'Now dear, you don't really mean that, do you?' He means, 'The reality of your desires is not admissible to me.'

The mother says to her daughter, 'Why must you always try to get your own way?' She means, 'Your own desires are not an acceptable basis for the conduct of your life.'

The father says to his daughter, 'You are a great help to me, dear. I don't know what I'd do without you!' He means, 'If you don't do it for me I will leave you!'

The mother says to her son in desperation, 'If you don't behave and do what I tell you, I just don't know what I'll do!' She means, 'Go ahead and do it — I won't try to stop you!'

The mother says to her daughter recalcitrant at feeding, 'I am going upstairs and when I return I want to see your plate all cleaned up!' She means, 'If you do not eat, I will leave you!'

Such words might be ordinary talk in the mouths of others. But to these parents, spoken in a certain fashion at a particular time with other words unsaid, the sentences convey the charged details of a secret treaty.

Children love secrets. As viewed through the magnifying glass of childhood, secrets are one of the brightest trappings of the grown-up world. The prestige of being despatched upon a secret mission is a source of great exhilaration for the child. It is a bonus he receives in reward for sacrificing the knowledge of his own wants and his own goals in order to serve his parent.

Furthermore, the pact is drawn up in the special language of an adult addressing a child as if he were endowed with the psychic equipment of an adult. The vocabulary of adult appetites and morality is used to bully, exhort and ride herd on the instincts of childhood.

If one hunts a fly with an elephant gun, after a while the fly begins to think of itself as an elephant. So too the exploited child comes to view himself as an adult. With his special rewards there are special burdens. But because the true terms of the pact are hidden beyond the reach of consciousness, they are not available for re-negotiation through the direct use of words or actions to express affects.

A re-negotiation of the terms basic to the maintenance of the parentage contract often ensues upon the development of an alteration in the child's body either in locus, function or both. The child may run away from the parent. The parent may send the child away from him. Accidents, fractures, burns, poisonings, feeding disorders, a variety of hysterical afflictions of the motor or sensory functions of the nervous system, the onset of anorexia nervosa, ulcerative colitis, systemic lupus erythematosus and rheumatoid arthritis have been observed to occur in children who had been exploited by their parents. The onset of these conditions was followed by a dramatic though transient change in the nature of the relationship of the parent and the child and the terms upon which they lived together.

Summary

The battered child, the neglected child and the exploited child each represent a dysfunction of parenting in which culture of the child has been sacrificed for the maintenance of the parent's psychological homeostasis.

The battered child responds acutely with a pattern of fright or flight into immobility. Recovery is usually prompt with appropriate treatment. The most apparent sequel is the persistence of a sadomasochistic mode of relating to the world. The battered child retains the ability to relate to others. The warmth of wrath appears to sustain his sense of self.

The neglected child responds with a failure to thrive physically and/or psychologically. The isolation imposed by a parent who is present but inaccessible deprives the child of a human with whom to live. His capacities arrive in accordance with his biologic stage but he fails to exercise or develop them for want of another's interest in his presence. The condition is reversible with vigorous and appropriate treatment aimed at providing the child with human contact to evoke pleasure at the exercise of his skills. Defects in the establishment of a hierarchy of relationships persist and the neglected child likely retains a promiscuous attitude towards others. The chill of indifference appears to blight his sense of self.

The exploited child responds by distorting his development to accommodate to his parent's intrapsychic requirements. He fails to harness his behaviour to his appetites in favour of serving his parent's needs. The exploited child appears particularly vulnerable to the development of disturbance in his physical functions. Treatment is aimed at separating the parent's need from the child's function so that each may better serve himself. A frequent sequel is the recurrent liability to exploitation by others as a source of a sense of self.

The parent who batters his child hates some part of himself which he projects on to the child. He beats the child to exorcize that attribute while still retaining that part of the child he loves.

The parent who neglects his child hates some part of himself which he denies. To avoid his self-hatred he must avoid the child in whom he fears to see himself.

The parent who exploits his child attempts to retain ownership of the elements of a personal conflict. He takes the child in partnership assigning to him a function which spares the parent from conscious suffering while preserving his integrity.

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The Abused Child: A Typology for Classification and Treatment

Serapio Richard Zalba

A problem/treatment typology is presented for families in which there has been physical abuse (i.e., injury) of children by parents. Each of the categories specifies (1) the immediate danger to the child, (2) the locus of the dysfunction in the child-parent relationship, and (3) the immediate reason for the aggression/abuse. In addition, treatment objectives are outlined and treatment strategy is linked, point by point, with the objectives.

In Part I of this paper the writer reviewed the recent literature on child abuse, attempting to provide a perspective on the dynamics of this system of problem behavior and the parameters of its occurrence.[1] There is little question that the abuse of children, sometimes unto death, is and must be of serious concern to social work, and indeed to the larger society itself.

Admittedly there is no clear demarcation between severe punishment and abuse. The extreme positions on the continuum are, however, fairly clear. A mild spanking on the buttocks of a 2-year-old child is quite different from the case of abuse found by a protective agency, where a child may have had scalding water poured on his genitals by a cruel, disturbed parent, or may have been beaten until unconscious.[2]

Attempts to identify cases of child abuse (sometimes called the "battered child syndrome") encounter formidable obstacles.[3] Once the worker has identified a case, he has the difficult task of deciding what to do about it. The removal of the abused child from his home may be one solution, but not necessarily the best one. Other possible interventions must be considered, especially when there are a number of children in the home, some of whom may not have been abused (as is often the case). The relatively limited literature on the abused child has not yet provided us with a systematic problem/treatment typology that might serve as a guide in the formulation of intervention strategy in child abuse cases. It is the intent of this paper to make a beginning attempt at outlining such a typology in the hope of providing the rudiments of a guide, however crude, for planning intervention strategy. It would further serve as a take-off point for the development of increasingly sophisticated and viable typologies validated empirically by field studies.[4]

Analysis of human behavior

A prescriptive typology requires the systematic identification of (1) where the basic problem lies, (2) what causes and maintains the problem behavior despite pressures toward social conformity, and (3) what can be done to eliminate or ameliorate the problem and its consequences.[5] The salient organizing principles in constructing a classification scheme in a specified behavior system — i.e., child abuse — have some relevance in a more general frame of reference in that the determinants of human behavior in the variety of behavior systems that society labels "problem behavior" (e.g., juvenile delinquency, mental illness, financial dependency) consist of elements along the same general dimensions. Thus, a typology for problem/treatment classification in a specific behavior system will reflect an underlying approach to the explanation of human behavior in general. In addition, however, the typology should account for the typical and recurring features of cases in the specific problem area under consideration. Logically or theoretically possible categories for which cases do not occur empirically may help to provide theoretical closure to a classification scheme, but they are of little practical value; consequently they will not be dealt with in this paper.

In social work, human behavior is typically seen as being determined by the following factors:

1. The individual's personality system (e.g., his basic pattern of id/ego/superego functioning).

2. His significant interpersonal relationships — especially the nuclear family of which he is a current member, but also extended kinship and important friendship and work (and other activity-oriented) relationships.

3. His values, which reflect cultural and subcultural influences.

4. The number, complexity, and congruence of -- and his relative mastery over -- the social roles he performs.

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5. His physical makeup and condition — i.e., physical assets, liabilities, disabilities, chronic or acute illness, and so on.

6. The amount of stress or support provided by the external environment, in physical-social-cultural-political-economic resource terms (e.g., depression, discrimination, opportunity, rapid social change, barren terrain, and natural catastrophes).

The identification of the primary or crucial factor precipitating or maintaining a specific case of child-abusing behavior should be made by considering the data about the case from the perspective afforded by the analytic framework described above. A determination then must be made of what aspect of the case is most relevant in classifying it in such a way as to indicate the most efficacious intervention. The point made here is that the basis for typological classification does not necessarily follow the logic of causation categories. On the contrary — when the major purpose of the typological system is to organize cases according to similarities in their intervention strategies, other principles of classification may be followed. Such is the case in the typological system to be outlined here, where classification will be made along the dimensions of locus of the problem (e.g., personal system, family system, social system, and so forth), ability of the abusive person to control such behavior, and the psychosocial source of abusive behavior.[6]

Unit of classification

The unit of classification in the typology to be developed here will be the family. In arriving at the diagnostic/treatment classification of a specific family, attention must be paid to the way in which the various members of the family system impinge on one another, and how factors external to the family system (e.g., the external environment) affect transactions within the family system.[7]

First, however, let us consider what the literature says about the behavior system of child abuse — facts for which a typology must account. In summary:

1. In many cases only one of a number of children in the family is chosen as the target of abuse, and frequently that child was conceived or born extra-maritally or premaritally.[8]

2. Marital partners tend to protect the abusive parent from disclosure or prosecution through patent denial of obvious facts.[9]

3. Occasionally an abusing father also abuses his wife, but more frequently he restricts his serious abuse to his children.[10]

4. Some abusive parents are generally abusive, getting into altercations with the spouse, casual drinking acquaintances, and so on.[11]

5. The parents in child abuse cases tend to resist the interventions of social agencies even when these are directed toward the children alone (in contradistinction to neglectful parents, who do not seem to mind interventions, even when these include removal of or attention to the children).[12]

6. Many of the homes involved meet or exceed middle-class standards for furnishings and cleanliness; the parents in them may be generally perceived as "upstanding citizens," although cold and rigid.[13]

7. In over half the cases in which child abuse results in hospitalization there is precedent or subsequent abuse of equal severity.[14]

8. Not infrequently the battered child requiring multiple hospitalizations is taken to a series of different hospitals in order to conceal the recurrence of injuries, which might arouse suspicion as to their causation.[15]

9. The abusive parent is most often impulse-ridden, with a great deal of marital and family conflict and faulty community relations.[16]

10. Many abusive parents had experienced abuse as children.[17]

11. Children tend to have impaired relationships with the abusive parent.

12. Abused children tend to be depressive, hyperactive, destructive, fearful, withdrawn, bed-wetters, truants, and firesetters; they overreact to hostility.[18]

These data seem to provide a clear justification for using the family as the unit of classification. The demands made on the individual in his role as parent and as spouse seem clearly related to the frustrations, hostility, and subsequent violent actions of many of the abusive parents. Indeed, Morris and Gould conceptualize some child abuse as being an outcome of "role reversal," wherein the parents had expectations that children would meet their needs rather than require need-meeting services on the part of the parents.[19] In other cases one gets the impression that the complicity of the other parent in not disclosing the actions of the abusive one and the resistance of both to removal of the ostensibly unvalued child are related to a desire to keep the scapegoat who acts as the object of displaced or reflected hostility arising out of marital conflict, disappointments, and inadequacies. In any case of child abuse by a parent or parent substitute the abuse is an intrafamilial transaction and consequently, a family matter.

Treatment prescriptions

An attempt will be made to identify the most efficacious treatment specifics that correspond to the various classifications that are constructed. Perhaps the term "treatment specific" is misleading in view of the writer's conviction that only broad interventive strategies — e.g., removal of a child from his home — can be prescribed for a case away from the actual treatment situation. However, the term is useful in this discussion because unless even broad interventive strategies can be shown to be specific for a particular problem classification, the problem typology will be useless as a guide for formulating intervention strategies.

There is a balancing consideration that limits the specificity with which interventive prescription can be made: discrete acts of intervention tend to be made on a tactical basis — in response to a concrete "here-and-now" issue that arises during an interview or group meeting (or other social work practice circumstance) when the issue could not necessarily have been predicted in advance.[20] The differentiation being made is between broad strategies of interventive entry in a case, which can be determined in a diagnostic staffing, and the "on-the-scene" tactics and techniques of the practitioner. The latter decisions can be made only "on site."[21] This is part of the reason social work practice is referred to as an art.

The relevant literature provides some principles that should be kept in mind in developing treatment prescriptions in child abuse cases:

1. Emergency treatment alone is useless and dangerous.[22]

2. An attempt should be made to keep the child in the home; often he falls apart when removed, even from an extremely poor (historically) environment.[23]

3. Clients in child abuse cases tend to respond positively to authority.[24]

4. Prognosis is best when parents show guilt, anxiety, and concern over the children, rather than being mainly concerned with what will be done to them as abusers.[25]

5. Protective service workers must beware of surface compliance, which is designed primarily to get the agency personnel out of the picture.[26]

6. Continuity of treatment, despite client rebuffs, acting-out, and testing, is extremely important in view of typical histories of perceived rejection, unlovability, and the like.[27]

7. Removal of parent or child from the home is an event of great stress for the family, requiring casework services to minimize the psychological and social traumata.

8. Group treatment may be the method of choice for the abusive parent, the marital couple, or even the whole family.[28]

Construction of typology

The problem typology will be constructed along three dimensions (see Table 1 for a schematic of case classifications):

TABLE 1. SCHEMATIC OF CASE CLASSIFICATIONS

Locus of problem	Control over abuse Uncontrollable Abuse	Controllable Abuse
Personality system	I. Psychotic parent II. Pervasively angry and abusive parent III. Depressive, passive-aggressive parent	IV. Cold, compulsive, disciplinarian parent
Family system		V. Impulsive but generally adequate parent with marital conflict
Person-environment or family-environment system		VI. Parent with identity/role crisis

1. The immediate danger of further harm to the child within the family structure as currently composed, despite interventive efforts short of removal of child or parent from the home (i.e., the ability of the abusive parent to control his abusive behavior).

2. The locus of the dysfunction that eventuates in child abuse (e.g., psychosis in the individual, the individual's general inability to control aggressive and hostile impulses, marital conflict, or resentment toward an extra-maritally conceived child; problems located in the family system; problems located in the person-environment or family-environment system).

3. The immediate reason for the hostility that is vented on the abused child.[29]

The treatment prescriptions that are linked to specific problem categories will be made with regard to treatment objectives and treatment strategy for (1) the abused child or children, (2) the abusive parent, and (3) other members of the family unit. It should be noted that the lower case letters representing treatment strategies are linked to the corresponding upper case letters representing treatment objectives.

Typology: Uncontrollable abuse

Classification I. Psychotic parent.

> Abuse is unpredictable, ritualistic, sometimes violent; it has idiosyncratic meaning related to the fantasies of the abuser. Infanticide and child homicide most often fall into this category.[30] The children are in grave danger.

Treatment Objectives	*Treatment Strategy*
A. Separation of abuser and children.	a. Use of aggressive casework with legal sanctions, including court wardship and law enforcement intervention when needed; commitment of abusive parent to a psychiatric institution; provision of homemaker services or foster home placement when needed.
B. Stabilization of family environment through the provision of psychological and material support and realistic, viable plans for the short and long run.	b. Supportive casework, coordinating, and referral services; assistance in reality planning for the family for the present and the future; assistance in obtaining needed material resources; homemaker services when needed.
C. Resolution of residual psychosocial problems of children and parents.	c. Children are often fearful, anxious, withdrawn, and require reassurance and stable, nurturing relationships that can be provided by a caseworker, a Big Brother or Big Sister, a community center group worker, and so on.
	cc. The remaining parent may need a supportive relationship with a caseworker.
	ccc. The psychotic parent requires psychiatric treatment. Treatment prognosis is poor.
D. Maintenance of separation until significant change in the abuser makes reunion safe.	d. Supervision over the family situation to insure that precipitous reunion is avoided.[31]

Classification II. Pervasively angry and abusive parent[32]

> Abuse is an impulsive and unfettered expression of general rage and hostility, which is part of the person's childhood-determined personality and character. Personal inadequacy, alcoholism, evictions, poor housekeeping and financial management, and irresponsibility are typical, as is illegitimacy. There is a preponderance of women in this category — there is no father in the home in over half these families; when the father is present, there is severe and open marital conflict. There is no pattern of abuse; all children in the family are abused. Most often the abused children are over 5 years old and are rebelling against parental values; however, these homes are very dangerous for infants.[33]

Treatment Objectives	*Treatment Strategy*
Same as for Classification I.	a. Same as for Classification I except that jail or prison is a more appropriate facility for custody and control.

b. Same as for Classification I.

c. Same as for Classification I.

cc. Authority and relationship-based treatment for the abusive parent, with consistent and appropriate limit-setting and supervision (e.g., probation); group treatment aimed at socialization (i.e., awareness of effect of self on others, interpersonal satisfactions, and group-sanctioned support for social control).[34] Prognosis is generally poor.

d. Same as for Classification I.

Classification III. Depressive, passive-aggresive parent.[35]

> Abuse represents resentment and anger at having to meet the needs of others[36] and at inability to meet the role expectations of a nurturing parent (the parent's personality feature — dependency — limits his ability to meet societal role demands). Children are seen as competitors for resources and attention. The abuser often seems unassuming and reticent about expressing feelings and desires, depressed, unhappy, and unresponsive; he is not sure he wants a marriage, home, or children. Usually only one child is abused, but sometimes all of them are. The children are in grave danger.[37]

Treatment Objectives	*Treatment Strategy*
Same as for Classification I.	a. Use of aggressive casework with legal sanctions, including court wardship and law enforcement intervention when needed; removal of abusive parent; provision of homemaker services or foster home placement when needed.

aa. It may be that only one child was abused. If others seem safe, it may be best to remove only the abused child and consider long-term foster care or relinquishment for eventual adoption. Leaving the nonabused children in the home should be contingent on treatment of the abusive parent and supervision of the home by a protective agency.

b. Same as for Classification I.

c. Same as for Classification I.

cc. Relationship-based therapy for the abusive parent (as described by Reiner and Kaufman for character-disordered adults).[38] Prognosis is poor.

d. Same as for Classification I.

Typology: Controllable abuse

Classification IV. Cold, compulsive, disciplinarian parent.

> Abuse is in reaction to the children's need for closeness and affection, interest in body and sex (the parent's personality feature — compulsiveness — limits his ability to meet societal role demands). Such parents have compulsively clean homes, avoid dirt and sex, cannot relax or talk well; they are cold, rigid, not friendly or warm; often they are upstanding citizens. Their main concern is with their own pleasures; they are unable to feel love or protectiveness toward their children. They defend their right to discipline (i.e., abuse) their children, who are usually over 7 years old and are generally abused with implements (e.g., belts, sticks, pokers, and the like) rather than by direct contact with hands or fists; abuse may be coldly sadistic. When confronted with societal intervention,

these parents will appear to conform (at least temporarily) in order to effect termination of the service (i.e., surveillance).[39]

Treatment Objectives	*Treatment Strategy*
A. Control over parents' abusive behavior.	a. Home supervision (i.e., surveillance), with legal child protective sanctions (e.g., probation), until alterations in intrafamily dynamics indicate that the children are no longer in danger.
B. Development of greater parental self-awareness of own feelings and ways of expressing them; trust in self and others, and consequent improvement in marital and parental role performances.	b. Group therapy for both parents in order to explicate fears of warmth, intimacy, feelings, and loss; learning to express, give, and receive emotionally oriented communication and behavior in more direct (i.e., not displaced) and socially acceptable ways; get realistic feedback (i.e., reality confrontation) of own role behavior and alternative behaviors utilized by others, in a protected environment (i.e., the group).[40]
C. Resolution of residual problems, mainly of the children.	c. Same as for Classification I.

Classification V. Impulsive, but generally adequate, parent with marital conflict.[41]

Abuse is the result of marital conflict displaced onto a child. In many of these cases there was premarital conception or birth and abuse was limited to the child involved (who was usually over 5 years old). The abuser (usually the father) can control his behavior and manifests anxiety over it; homes are generally neat and adequate; the children in the family tend to be bed-wetters, truants, fire-setters, and withdrawn; there is rarely danger of the death of a child through abuse.

Treatment Objectives	*Treatment Strategy*
A. Control over abusive behavior.	a. Same as for Classification IV.
B. Development of awareness that abuse represents a displacement of frustration and aggression toward the spouse; the establishment of more direct and satisfying communication among all members of the family system (vis-a-vis child abuse, marital satisfaction, and child behavior problems such as bed-wetting and fire-setting).	b. Group therapy for the parents or conjoint family therapy for the whole family.[42] When one parent dominates completely, individual treatment may be preferable; but since treatment should be aimed at exposing the marital conflict, its bases, and its part in the child abuse, and helping the family communicate more directly and less destructively, a group approach would seem to be the treatment of choice.
	bb. Psychotherapy for the abused child or children residual personality effects of abuse warrant intensive treatment.

Classification VI. Parent with identity/role crisis.

Abuse represents displaced anger at loss of capability for role performance, such as following bodily damage. Such parents are angry, controlled, rigid, disciplinarian; the women in this category are often alcoholics, promiscuous, arrested as vagrants (i.e., "lewd and lascivious"). This classification is similar to Classification IV, except that the abuse in this classification is a result of the stress of external factors (physical disability and change in role abilities and expectation -- e.g., the disabled man who stays home while his wife now becomes the wage-earner), or a personality not resilient enough to make the required role changes without threat or loss of identity. The locus of the problem in this classification is thus the person-environment system (rather than the person system, as in Classification IV).[43]

Treatment Objectives	*Treatment Strategy*
A. Control over abusive behavior.	a. Same as for Classification IV.
B. Development of awareness that abuse is a displacement of frustration and aggression felt because of inability to meet role demands and resultant identity crisis. Opportunity for direct expression of frustration and development of new and realistic conception of self, including development of new role skills.	b. Casework for expression of feelings, clarifications of self-image and others' expectations; elaboration of a realistic self-image; development of restorative social role skills. bb. Physical and vocational retraining when applicable.
C. Resolution of residual problems of other family members.	c. Same as for Classification I. cc. Same as for Classification I.

Summary

It can be seen that in the first three classifications of the typology it is not expected that abuse can be controlled without separation of the abusive parent from the children. The locus of the problem in each of those classes is the personal system of the abuser, the basic determinant being personality structure (or lack of adequate development in certain personality functions). For Classification IV, the cold, compulsive parent, the problem is also centered in the basic personality or character of the abusive parent, but here the abuser has control over such behavior (i.e., can respond to social environmental pressures), and hidden marital conflict is a contributing factor. For Classification V, the problem is located primarily in the marital system — i.e., the family system — and for Classification VI, in the person-environment system. In each of these classes the abuse of the children is generally amenable to control by methods other than separation of children and parent(s).

When the problem is located in the individual system primarily (i.e., Classifications I, II and III) the treatment prescribed tends to be individually based.[44] When the problem is located primarily in the individual but marital or intrafamilial interaction is an important contributory factor (i.e., Classification IV), individual, group, or both treatment approaches may be indicated. When the problem is located in the person-environment system treatment may be addressed toward that system (e.g., increasing personal capability as with vocational rehabilitation, or reduced environmental demands, as in sheltered workshops).

From Classification I to Classification VI there is also a progression in improved prognosis for change in the abusive parent and prospects for the improved functioning of the total family as a system.

The treatment strategies specified are primarily differentiated in terms of (1) authority-based control and environmental manipulation (e.g., institutional committment of parent or removal of child), (2) reality-based planning and use of community resources for child care, financial assistance, and so on, (3) relationship-based casework (as described by Reiner and Kaufman),[45] (4) traditional psychoanalytically oriented psychotherapy, (5) psychiatric treatment (for psychotics), (6) activity/relationship treatment, as in Big Brothers, youth development services (e.g., scouts, community centers, and the like), (7) group therapy (when social performance and relationship dynamics are confronted and awareness and skills in interpersonal relations are developed), (8) conjoint family therapy, and (9) ego-supportive surveillance (as is typical in correctional treatment). Specific descriptions of each kind of treatment are not provided herein, since they are readily available in the literature.

As was pointed out by Shumway regarding his own effort to develop a problem/treatment typology for school attendance problems, the principles underlying the construction of the classification system developed in this paper are not new to social work.[46] Consequently, the classifications and the treatment prescriptions linked to them are likewise not novel. It is the hope of the writer, however, that this paper has brought together a number of elements that heretofore have been scattered throughout the literature. If this aim has been accomplished, the effort will have been of value. In addition, while the problem characteristics and classifications are taken directly from the empirically based literature (i.e., Merril, Delsordo, Reiner and Kaufman, Elmer, Boardman, and Nurse), the treatment strategy linkages are not. Thus, they represent problems in validation and refinement — an action-research task.

References

[1] Serapio Richard Zalba, "The Abused Child: I. A Survey of the Problem," Social Work, Vol. 11, No. 4 (October 1966), pp. 3-16. The concept "behavior system" involves the consideration of recurrent, patterned behavior as consisting of a multiplicity of specific behaviors that are interrelated with one another, are functional within the system, and take into consideration cultural values, social roles, personality, and environmental reality factors. This concept is related to Merton's conception of deviant behavior as being determined by and being a function of social structure — i.e., of social systems. See Robert K. Merton, So-

cial Theory and Social Structure (New York: Free Press of Glencoe, 1962.) Greater emphasis, however, must be placed on the influence of the personality as it develops first in childhood within the family system and subsequently during adult life experiences. Thus, Freudian personality theory is relevant and will be utilized as part of the theoretical framework for this paper. However, the writer agrees with Merton's objection that the psychoanalytic point of view tends to explain deviant behavior almost exclusively on the basis of intrapsychic factors. Consequently, role theory and systems theory will also be utilized as part of the theoretical frame of reference. The author is indebted to Dr. Elizabeth Meier for encouragement and advice in the development of this typology and in the writing of this paper.

[2] See Edgar J. Merrill, "Physical Abuse of Children — An Agency Study," in Protecting the Battered Child (Denver: American Humane Association, 1962), pp. 1-16; Harold D. Bryant et al., "Physical Abuse of Children in an Agency Study," Child Welfare, Vol. 42, No. 3 (March 1963), pp. 125-130.

[3] The term "battered child syndrome" was coined by Dr. Henry C. Kempe and his associates. See Kempe et al., "The Battered Child Syndrome," Journal of the American Medical Association, Vol. 181, No. 1 (July 7, 1962), p. 17. For a discussion of the obstacles to recognition of cases of child abuse see Zalba, op. cit., pp. 8-9.

[4] The pioneering classification efforts of Delsordo and the team of investigators at the Massachusetts SPCC must be acknowledged appreciatively by subsequent venturers in this field. See James D. Delsordo, "Protective Casework for Abused Children," Children, Vol. 10, No. 6 (November-December 1963), pp. 213-218, Bryant, op. cit.; and Merrill, op. cit.

[5] See the discussion of the requirements of typologies in Samuel Finestone, "Issues Involved in Developing Diagnostic Classifications for Casework," in Casework Papers 1960 (New York: Family Service Association of America, 1960).

[6] Ibid.

[7] See Marian G. Morris, Robert W. Gould, and Patricia J. Matthews, "Toward Prevention of Child Abuse," Children, Vol. 11, No. 2 (March-April 1964), who suggest taking into account many of the same factors.

[8] Helen E. Boardman, "A Project to Rescue Children from Inflicted Injury," Social Work, Vol. 7, No. 1 (January 1962), pp. 43-51; Bryant et al., op. cit.; Delsordo, op. cit., Henry C. Kempe et al., op. cit.; Shirley M. Nurse, "Parents Who Abuse Their Children," Smith College Studies in Social Work, Vol. 35, No. 4 (October 1964), pp. 11-25

[9] Boardman, op. cit.; Nurse, op. cit.

[10] Delsordo, op. cit.; Merrill, op. cit.

[11] Ibid.

[12] Leontine Young, Wednesday's Children (New York: McGraw Hill Book Co., 1964).

[13] Merrill, op. cit.

[14] Elizabeth Elmer, "Identification of Abused Children," Children, Vol. 10, No. 5 (September-October 1963), pp. 180-184; Kempe et al., op. cit.

[15] Boardman, op. cit.

[16] Bryant et al., op. cit.; Kempe et al., op. cit.; Merrill, op. cit.

[17] Bryant et al., op. cit.; Kempe et al., op. cit.; Morris et al., op. cit.; Planning for the Protection and Care of Neglected Children in California (Sacramento: National Study Service, 1964); Beatrice Simcox Reiner and Irving Kaufman, Character Disorders in Parents of Delinquents (New York: Family Service Association of America, 1959).

[18] Bryant et al., op. cit.; Delsordo, op. cit.

[19] Marian G. Morris and Robert W. Gould, "Role Reversal: A Concept in Dealing with the Neglected/Battered-Child Syndrome," in The Neglected/Battered-Child Syndrome (New York: Child Welfare League of America, 1963).

[20] See Martin Bloom, "Connecting Formal Behavioral Science Theory to Individual Social Work Practice," Social Service Review, Vol. 39, No. 1 (March 1965), who differentiates between strategies and tactics. Roy Grinker, on the other hand, takes the more extreme view that all decisions are tactical. See "A Transactional Model for Psychotherapy," in Morris I. Stein, ed., Contemporary Psychotherapies (New York: Free Press of Glencoe, 1961), pp. 190-213.

[21] The tactical skills of practitioners can be *fostered* through review and analysis of what has been done in a case, and the consequent outcomes of the tactics used.

[22] Bryant *et al.*, *op. cit.*; Delsordo, *op. cit.*; Elizabeth Barry Philbrick, *Treating Parental Pathology Through Child Protective Services* (Denver: Children's Division, American Humane Association, 1960); Reiner and Kaufman, *op. cit.*

[23] Irving Kaufman, "Psychiatric Implications of Physical Abuse of Children," in *Protecting the Battered Child* (Denver: American Humane Association, 1962), pp. 17-22.

[24] Reiner and Kaufman, *op. cit.*

[25] Delsordo, *op. cit.*

[26] *Ibid.*

[27] Reiner and Kaufman, *op. cit.*

[28] J.E. Neighbor *et al.*, "An Approach to the Selection of Patients for Group Therapy," in Max Rosenbaum and Milton Berger, eds., *Group Psychotherapy and Group Function* (New York: Basic Books, 1963).

[29] Finestone, *op. cit.* See also Merrill, *op. cit.*

[30] Lester Adelson, "Slaughter of the Innocents," *New England Journal of Medicine*, Vol. 264 (1961), pp. 1345-1349; Delsordo, *op. cit.*; Kaufman, *op. cit.*; Kempe *et al.*, *op. cit.*

[31] Delsordo, op. cit.

[32] This term was suggested by Elizabeth Meier, professor, School of Applied Social Sciences, Western Reserve University, Cleveland, Ohio.

[33] Delsordo, *op. cit.*; Eustace Chesser, *Cruelty to Children* (New York: Philosophical Library, 1952).

[34] See, for example, Neighbor *et al.*, *op. cit.*

[35] This is the group of cases generally discussed in hospital studies under the term "Battered Child Syndrome." See, for example, Kempe *et al.*, *op. cit.*; Boardman, *op. cit.*; and Elizabeth Elmer, "Abused Children Seen in Hospitals," *Social Work*, Vol. 5, No. 4 (October 1960), pp. 98-102.

[36] This is the role-reversal dynamic described by Morris and Gould, *op. cit.*

[37] Delsordo, *op. cit.*; Merrill, *op. cit.*

[38] *Op. cit.*

[39] Delsordo, *op. cit.*; Merrill, *op. cit.*

[40] See, for example, Neighbor *et al.*, *op. cit.*

[41] This classification takes in approximately one-half of Delsordo's child abuse cases.

[42] See, for example, Don D. Jackson and J.H. Weakland, "Conjoint Family Therapy; Some Considerations in Theory, Technique, and Results," *Psychiatry*, Vol. 24 (1961), pp. 30-45.

[43] Merrill, *op. cit.*

[44] For Classification II (pervasively angry and abusive parents), group treatment may be efficacious in view of the experiences of correctional agencies in group treatment of similar clients.

[45] *Op. cit.*

[46] E. Gene Shumway, "A Diagnostic and Treatment Typology for School Attendance Problems." Unpublished manuscript, Cleveland, Ohio, 1965.

Prevalent Types of Neglectful Mothers

Norman A. Polansky

The types of personalities observed most frequently among mothers in situations of child neglect are:

A. The Apathetic-Futile Mother
B. The Impulse-Ridden Mother
C. The Mentally Retarded Mother
D. The Mother in a Reactive Depression
E. The Psychotic Mother.

The first three categories have many characteristics in common. They have often been lumped together in the literature as *the* neglectful mother. However, they have significant differences as well as commonalities.

The apathetic-futile mother

Identification

> Mrs. Cole is a passive woman who shows very little reaction either to the way she lives or to what happens to her. When her husband left her, when her brother was killed in an accident, and when her father died, she displayed no outward signs of emotion.
>
> From the time she was first married she has lived in a little house built by her husband and her father on land belonging to her family. Once described as "a cute little place," it is now referred to as a "shack located in the middle of a yard full of debris." The inside of the house matches the filth outside. The children are unbelievably dirty, running through the trash barefooted, frequently getting infections from cuts and scratches.
>
> After completing the 8th grade, Mrs. Cole dropped out of school completely. After she found summer work in a motel, she simply never returned. She worked a year, got married, and has never worked outside the home since. She reads and writes fairly well, and qualified for vocational training when she reluctantly went for testing.
>
> No client has ever been more agreeable than Mrs. Cole; she never argues. In fact, she just does not talk about anything. After 2 years of effort met with her passive, stubborn resistance, her caseworker says, "I just don't get a good picture of her. As a matter of fact, I now hate to go to visit her."

It is probable that every caseworker has encountered more than one Mrs. Cole. She is always at home in body, but there is never any evidence that she has done anything. She may show a flurry of activity — cook a pot of beans or rinse out a few clothes — but nothing really seems worth the effort. And she relates to her family the same way she relates to her worker. She is scarcely aware of the children; her husband, when he stays with her, is given the same low-energy response.

The personality characteristics of the so-called Apathy-Futility syndrome are:

1. A pervasive aura that nothing is really worth doing. These women seldom go after anything with a sense of energy or purpose, and they seem unresponsive to attempts to mobilize them.

2. Emotional numbness, which is sometimes taken as depressiveness but is not so alive as depression.

3. Absence of intense personal relationships beyond a kind of forlorn clinging, even to her children.

4. Expression of anger passive-aggressively, especially in defiance of authority figures.

5. Low competence in most areas, often visibly associated with fear of failure and unwillingness to invest energy to acquire skills.

6. Noncommitment to positive stands and low self-confidence, which contrast with her persistence in stubborn negativism.

7. An almost uncanny ability to infect those who try to help with the same feeling of futility.

8. Verbal inaccessibility regarding important feelings and difficulty in facilitating the thinking through of problems by talking.

From "Prevalent Types of Neglectful Mothers," in *Child Neglect: Understanding and Reaching the Parent*, Norman A. Polansky, 1972, *Child Welfare League of America, Inc.*, pp. 21-53. Reprinted by permission of the Child Welfare League of America, Inc.

It may be hard to distinguish the symptoms of Apathy-Futility from depression. However, in depression the client's feelings are awful, but she does feel. In Apathy-Futility there is numbness. She seems to be saying, "I will feel nothing, and then I cannot be hurt." She is no more able to show love than she is to show real anger. The attitude that "nothing is worthwhile," in other words, is a way of avoiding the involvement that would lead to experiencing her emotions more vividly.

Every human being passes through a stage in which it is necessary to decide, in effect, whether life is worth living; each of us has some capacity to succumb to futility or hopelessness. Therefore the atmosphere these women give off finds echoes in each of us. Besides the frustration we experience when we try to mobilize them to action, their attitude stirs remembrances of our own sense of futility. This is why being around them is so infectious, and why we come to dislike them.

A full-blown case of Apathy-Futility may easily be taken for a case of retardation. However, there are leads in the conversation, such as it is, the choice of words and the like; we also usually know if a woman, such as Mrs. Cole, can write perfectly well when she wants to. Of course, it is possible to be both retarded and apathetic.

Etiology

How did Mrs. Cole get to be the way she is? By what chain of life events are we now confronted with so lethargic and unmotivated a client? In this instance, there is the advantage of a previous DPW record that tells a long tale of poor education in the grandparents, poverty and alcoholism. For years, they barely managed on the father's small income as a logger. When he retired, he drew an even more limited social security check. Neither of Mrs. Cole's parents had more than a year or so of formal education. Mrs. Cole, her brother and her sister were frequently kept home from school to take care of their inebriated mother or father, or both. Even after the children were grown, they were kept nearby to care for parents who had imbibed too much. None of these children ever broke away. Mrs. Cole married while still young and had five children in rapid succession. Eventually her husband was driven off by her family, even though legally he would be said to have deserted.

Mrs. Cole, with five youngsters, and her unmarried sister, with four, continue to live on the family property. (Mobility is not an outstanding characteristic of those with the Apathy-Futility syndrome.) The brother, who never married, was shot in a neighborhood brawl. The father died recently, leaving his aged widow to carry on, still drinking and still demanding care from her now grown children.

The women we have termed Apathetic-Futile are, in psychiatric jargon, far out on the "schizoid spectrum." That is, they are not schizophrenic, but they are withdrawn and show other disorders. A marked feature is their detachment. They hold back, refusing to invest energy or attention in the world around them.

To understand the feelings of persons who are schizoid, one must go back to infancy, when the infant is completely dependent on his mother. The mother who is the source of the milk of life is, by the same token, the woman who frustrates the infant. This is because even the best of mothers cannot be constantly and immediately available to forestall every need and discomfort her infant may feel. The child's reaction to this is to become angry, for the original purpose of anger is to push the outside world around. Hence, we must surmise that everyone without exception starts life with a mixture of two powerful emotions toward his mother: yearning and anger, or if you will, love and hate.

If the mother is a dependable, loving person, the child discovers that even if she does not meet his needs immediately, she gets around to him in time. Insecurity gradually is overcome and the child resolves on the side of trust the basic dilemma that Erik Erikson has labeled "trust vs. mistrust." But there are children who are not so lucky, either because they have the sort of mother Mrs. Cole had, or because their otherwise loving and capable mothers were — at the time — in a depression because of the loss of a child or parent, or were ill, or unavailable due to some other life mishap.

There is another important emotion that occurs as a result of deprivation, and the more severe and unrelieved the deprivation, the worse the damage. Deprived infants become depressed. This feeling is likely to remain with them as an undercurrent throughout their lives unless they receive reassurance or compensation for it.

In order to avoid dreadful feelings of depression and anxiety, many such youngsters spontaneously erect a buffer within themselves. They go numb; they refuse to experience emotions at all. You will recall Mrs. Cole's lack of response to the death of her father, the shooting of her brother, the loss of her husband. Persons with this sort of numbness may be said to be detached.

The detachment serves a number of purposes. By refusing to get involved with other people, one escapes the danger of being hurt or of hurting someone. This issue is, of course, very much on the mind of a woman who starts out with such strong feelings of both love and hate against her mother; it is even more of a problem if she is still reacting in an all-or-none way, since the emotions she has are so powerful.

When she begins to love, she automatically feels anger and depression, and anxiety. So she prefers to keep her distance. She may, as did Mrs. Cole, break up her one real love-relationship with a man in favor of a series of one-night stands. Affairs do not make her so vulnerable, because she is less involved. But there are disadvantages, too. In order not to feel hate or depression, the infant, Mrs. Cole, learned to go numb. Now that she is anesthetized, however, life is passing her by, and she feels dead inside, empty, living and yet not living. Her detachment keeps her from forming close relationships, but there is a price for this, also. She is "safe," but she is lonely. There is nothing about Mrs. Cole's shutting the door on pain that promises she will cure her depression, for she has also shut the door on pleasure and enjoyment. No wonder, therefore, that she ends with an overpowering sense of futility. Futility, then is the predominant feeling; apathy is what we see in behavior.

Results in the Children

What difference will it make for Mrs. Cole's children that she is Apathetic-Futile? At least, she does not treat them as her parents treated her, and she is always with them. It is rare for such a woman to desert. Her type of neglect is more insidious, fostering fairly predictable characteristics in her children. In school the children are seen as withdrawn. They are also more lethargic as 5-year-olds than other youngsters their age. They do not avoid their teacher, but they cling to her. But this is not real affection, for she discovers they cling to strange adults, too, not out of special attachment but more because of a pervasive panic at being alone. We can only guess how this pattern will look in an older child or adult, but Mrs. Cole may be a fairly good example.

The Apathetic-Futile mother understandably does not have the energy or interest to provide much intellectual stimulation for her child. This showed perceptibly in results of psychological testing. When a mother was seen as highly Apathetic-Futile, her child scored lower than other children in both visual and motor skills. Lower intelligence goes along with having an Apathetic-Futile mother.

It is interesting to note how much of the pattern we are describing has been generally applied to the "cycle of poverty." It is not necessary to be poor, however, to experience the Apathy-Futility syndrome, nor, on the other hand, does poverty immunize one from severe emotional problems.

Treatment

With the high incidence of Apathy-Futility among neglectful mothers, and all-too-familiar results in their children, we are

properly charged with responsibility to do something despite their facility at making us feel helpless and hopeless. So far as the child is concerned, removal to a good foster home might seem the answer. But this is not always a ready or available solution. In any case, a useful foster care plan depends on successful involvement of the parent. We are left with no choice but to persist and try to reach the mother. Treating the Apathy-Futility syndrome is usually long, arduous and often unsuccessful. Despite this bleak outlook, some caseworkers who are skilled -- and stubborn -- continue to achieve results with a good proportion of such women. So there is always some hope for improving the mother's level of operating. In any event, this is a pattern whose depth and rigidity cannot be known until an attempt has been made to help the client change it.

Goals in casework treatment of the Apathetic-Futile client must be set by focusing on one small gain at a time. Self-support and employment for the Apathetic-Futile mother are frequently "paper goals." Typically, she has very little education, she has never held a job outside her home, and she has problems relating to those close to her, let alone an outside employer and fellow workers. One way to spoil any chance of success is by overambitiousness, expecting too much too soon.

The first objective, almost too elementary to mention, is making an initial relationship. A typical Apathetic-Futile mother is reluctant about new attachments because of her fear of how they will work out. The caseworker, therefore, cannot "come on too strong." He must insert himself into her life, but he must be gently intrusive lest he frighten her into retreat. On the other hand, interviews reach a stalemate when the worker himself is so passive he offers no guidance. One way to strike the necessary balance is to be firm and positive about practical things, while being careful not to force the relationship. While one works wholeheartedly to get necessary repairs to her stove or refrigerator, personal feelings between client and worker are left unspoken -- in the beginning.

It takes a number of visits for even a very beginning relationship to form; in fact, there is no time over the duration of contact when the worker can take it for granted. Suspiciousness and an urge to withdraw present continuing challenges. Present in the background is the mother's impulse to destroy any growing attachment to another person, and this, too, must be guarded against. If for reasons the worker cannot fathom the mother becomes sullen and hostile, it will not necessarily indicate that she dislikes him; it may spring from fear she is liking the worker too much.

The idea of setting goals by mutual agreement may be a good, professional one in most instances. But with the Apathetic-Futile client, it is an empty exercise. Any objectives involving a generally better life must be the worker's, and the client will believe them only after they have been demonstrated. More to the point are basic survival needs with which this mother is familiar, and which she may expect the worker to supply. There is general agreement that one has to do a great deal of concrete giving with most neglectful mothers in the form of money, food and services in the effort to get the family on its feet. This is certainly true with those who are Apathetic-Futile. This kind of concrete helping is a protection to the children, in part; it is also a means of maintaining a relationship with a clinging sort of woman.

Casework treatment techniques so neatly defined in the literature require certain character strengths in the client: desire to be helped; some notion of the kind of help wanted; and the ability to express herself verbally, for casework is a talking treatment. All these abilities are diminished in a woman with the Apathy-Futility syndrome, so of course the usual approach has to be markedly modified. In general, we can say there are three themes in treating her.

First, there is the calculated encouragement of dependency. We try to exploit the client's need to cling, for her own longer-range benefit. Second, there is the emphasis on treatment through increasing the mother's Verbal Accessibility. Both these approaches are described in detail in Chapter Five. Although these techniques are applicable in most cases of neglect, they are especially pertinent to helping the Apathetic-Futile mother.

The third theme is the role of the worker as guide to dealing with the outside world. This mother has multiple limitations, and it is up to her caseworker to supplement her strength as a person, especially in her mental functioning. She may have to be told things she needs to know — such as the fact that some detergents work well with cold water, or that certain diseases will pass from child to child unless precautions are taken. One might have to explain the danger of leaving kerosene or gasoline around in pop bottles, since young children are likely to sample the contents; the worker might have to look over the kitchen with her to shift poisons to the upper shelves. The mother might not realize how much more she can get for her food dollar by shopping in a market rather than buying piecemeal in a quick-shop store. And all mothers are known for the ease with which they can be exploited in exorbitant interest and special charges for credit that they do not immediately comprehend. To point such matters out to her at first will be taken as criticism, but after a relationship is well established, she will welcome the concern.

The worker may have to undertake maternal functions that are beyond the client, for example, dealing with school authorities or discussing pregnancy with an elder daughter. Sometimes the worker has to go with the mother into situations she finds frightening. (Often she will not admit they scare her; she just refuses to have anything to do with them.) This may include driving her children to the clinic, acting as both organizer and social icebreaker for her, and repeating the journey a number of times until she is comfortable enough to set out on her own.

Persons with the Apathy-Futility syndrome are emotionally crippled; all are less effective than they might be, but they vary in their impairment, and therefore in how much help they need. Putting a homemaker into the household is much in order in many instances, either for short-term or long-term "teaching," as a way of supplementing a persistently ineffective mother. Finally, if the depth of pathology is such that no improvement is likely, placement of her children is in order. They have to be protected and provided a chance of growing toward a normal life. Here too the worker provides a perspective beyond that of which the client is capable: she is unable to mother, even though she would like to.

The impulse-ridden mother

Early in our work on child neglect it became clear that marginal child care is associated with generalized immaturity in the maternal personality. Then two types of immaturity emerged. In addition to the Apathy-Futility Syndrome, a second group of mothers appeared who were restless and rebellious, seemingly the antithesis of the first.

Yet the two personality types are not entirely mutually exclusive. They shade into each other. We are all familiar with the predominantly lethargic woman who breaks out suddenly into episodes of impulsive behavior. She is the immobilized mother who, all at once, packs and moves into still another dilapidated house, or the withdrawn mother who turns up pregnant when one would have thought she had neither the energy nor the sex appeal to arrange this. On the other hand, the predominantly active mother, always on the go, may lapse into periods of quiet withdrawal not unlike apathy. From experiences like this, we learn that the two types have much in common and even trade symptoms with each other.

There is, however, one important difference between the two. Many of the Impulse-Ridden women are likely to rise to long periods of mature functioning. The Apathetic-Futile mother is rarely capable of performance approximating maturity.

Identification

The outstanding features of the Impulse-Ridden mother are:

She is restless;
she is unable to tolerate stress or frustration;
she is aggressive and defiant;
she craves excitement, movement, change;
she is manipulative of people.

> Mrs. Perez was an attractive but physically ailing divorcee who made a comfortable home in a trailer for herself and her two little girls after her husband disappeared. She was friendly with the neighbors and with several male companions. When she dated, a neighbor cared for her children. However, from time to time she did not return when scheduled. Then the neighbor would telephone the caseworker, who would move the children into the already crowded home of their grandparents, where they received care until their mother returned. Sometimes this would be a week later.
>
> Mrs. Perez' escapades have taken her to cities hundreds of miles away. When she returns, she offers a weak excuse, and then settles down into the role of sweet and competent mother — until the next time.

The impulsive mother is often completely adequate in most respects. She may prepare balanced meals for herself and her children. In our research we found that such women can give thoughtful and appropriate answers to a questionnaire about child-rearing practices. Her problem is not what she knows, so much as what she does. Taking off on an escapade, either with her husband or her boyfriend, is one example. Another is the buying splurge that upsets a whole month's budget. She seems unable to tolerate stable organization or "success" for long.

Impulse-Ridden mothers are found in all walks of life. If the woman is from the middle or upper class, there are usually others in the family and plenty of money to buffer the children against her thoughtlessness. Among the poor, there may be only the neighbors, and it is not uncommon for the police to be called in. Occasionally, even though the mother has a firm resolve to get home within the half-hour, the fact that young children have been left to fend for themselves results in tragedy.

Newspaper stories that report youngsters who have wandered from home and were not missed for a couple of hours, or the death of two infants in a fire while their parents were just down the road disclose instances of this type of mother. These women are typically more capable of emotion than the Apathetic-Futile. Nor are they so tormented about love and hate that they are unable to form relationships. Their problem is that they love, but superficially — like children.

Etiology

Less pervasively damaged than the Apathetic-Futile mothers, the Impulse-Ridden mothers have not undergone so much deprivation in their early childhoods. The critical issue with them is not whether they dare to love; the question is more whether they want to control themselves against strong impulses that strike them, and whether they are able to control themselves when they want to. This involves the process of how limiting behavior is learned.

The infant starts life with the potential for achieving such controls, but does not yet have them. Controls enter the personality by moving from the outside inside. First he goes through the motions to avoid pain; then he goes through them with some resentment, but to keep the love of someone important to him; eventually, however, he does it to please himself and finally he is hardly aware that any control is being exercised. Defiance is not even at issue.

It is extremely important for the young child to feel loved for this process to go smoothly. Otherwise he has nothing to lose by refusing to internalize his parents' standards. Similarly, he will not identify with them — take a model of them inside himself, as it were, in order to keep them close. On the other hand, control systems do not flourish when there is unconditional love. Unless there is effective parental limiting, the overindulged child has nothing to lose. He will not internalize his parents' standards either. Obviously, what is required is a parent who loves, but who also makes demands.

It is also extremely important that the demands experienced by the youngster be consistent. The weak, vacillating mother who sometimes controls and sometimes does not produces a child whose control systems are similarly spotty. This is also true of self-centered parents who "do not love their children enough to fight with them." Indeed, they do not give that much steady attention to the issue of how their children are growing up. Inconsistency also occurs when the two parents are in frequent disagreement about what they want. If mother's signals conflict too much with father's, no firm inner controls are developed.

Finally, one will occasionally encounter persons with surprising backgrounds who seem Impulse-Ridden. One woman, for example, had a father who was very strict and a fundamentalist — she was not allowed to date until she was 16 or 17. In such an instance, we are dealing with an immature conscience. Some women from such families only "behave" under the threat of external pressure. They were so used to "doing what Daddy said" that the controls never became internal, never their own.

Others, however, represent a further complication. They have childlike consciences that operate in stringent, all-or-none fashion. If sex is "bad" it is always bad, even with their husbands. They are so strict with themselves that they permit themselves no fun whatever. For some, such an approach to life becomes intolerable and they kick over the traces; but they go to an opposite extreme. Trying to demonstrate that they are liberated, they want to operate with practically no controls at all. A woman like this will seem highly impulsive. But unlike some others, she becomes guilty about her actions. Unfortunately, her guilt conveniently operates only after she has first had her escapade, so the results in the lives of her children may be the same.

Children with an Impulse-Ridden mother need protection first against the danger and discomfort into which their mother's escapades may bring them. They also need protection against growing up with the same spotty controls as the model before them. In one study we found that youngsters, even at age 5, showing hostile-defiant behavior had mothers rated high on impulsivity — a seed-bed for later delinquency.

Treatment

In a general way the treatment of the impulsive mother follows from knowledge of the way her difficulties got started. We seek to establish a relationship with her in which, as she comes to like and depend on us, our opinions matter to her. We then can use this leverage to encourage her to put limits on herself — first, perhaps, primarily to please us, but gradually in order to please herself. We try to help her see how her behavior creates unpleasantness for herself as well as her children. One emphasis is on her wants, her needs, as she prefers, with the aim of teaching her to delay her rush toward gratification for the sake of more satisfaction in the long run. The other emphasis is on helping her learn to "talk it all out rather than act it out." These are the principles. The practice is not easy. However, the worker is supported by the knowledge that others have had success with many Impulse-Ridden mothers.

Even though the impulsive mother is oriented to action rather than talking, or experiencing feelings, she usually has little trouble verbalizing her needs and wants. In fact, impossible demands on the worker, followed by righteous indignation if they are not met, are not at all uncommon. Her manipulations can be annoying when they are obvious, but some are so adroit that it is intriguing to try to keep up with them.

One woman was never at home when her worker was supposed to visit, but she would leave behind broad hints with a neighbor as to where she would be. The worker then tracked her down, and took her home where he could talk with her. His persistence in the face of her testing was finally rewarded when she stayed home to meet him, and told him that she had discovered that he really was on her side and wanted to help. Irritation with such ploys is alleviated when we stop regarding the client as a mother aged 25 or 30, but think of her behavior as that of an unruly child somewhere between 3 and 9.

That these mothers are unmotivated for treatment is inherent in their problems. Before the caseworker expects anything as organized as a client's desire to change herself, the first goal is simply to get involved, and go on from there. Contrary to gentle intrusiveness with the apathetic woman, here the worker's aim is to present himself as a person of strong character, unlikely to have his feelings hurt by the avoidance or demanding outbursts of the client. This does not mean being "hard," for the sense of caring for the client must also come through. But in the face of her manipulativeness, she will feel safer dealing with someone who is sturdy and not easily hurt or dismayed. The reason for one's entering the situation should be stated clearly and placidly.

There is always the question of what point to begin to try to introduce some controls. The minor manipulative tactics present relatively little problem from this standpoint. Almost from the beginning, it is all right in most instances to confront her with, "Well, I guess you really don't want to see me," or "Do you want me to chase you to find you?" and the like. On the other hand, confronting her about her major indiscretions takes finesse. If one lets oneself sound moralistic — and one may, of course, be shocked at something she has done — one only allies oneself with the other complaining authorities she has spent a lifetime teasing. A better tack is to concentrate on the disadvantages of her behavior to her, which is what is really most on her mind. It is as well if such reminders occur in the context of a relationship in which concrete assistance to the client has already been given. Once the client has some liking for the worker and has demonstrated need of him, her behavior and its consequences for her and for her children should be frankly discussed.

Eventually, as all experienced workers know, it is possible to have so strong a relationship with an impulsive mother that even an open quarrel is acceptable to her. This occurs in a setting of trust and intimacy, as it would in a family, in which the quarrel is truly about whether what she has done is to her own best interests.

The purpose of treatment is to reduce the confusion and frustration that drive this mother to do what she has been doing. We accomplish this by offering ourselves as teacher — and as models. We hope she will find better ways to manage her energies, so that the momentary fling does not reduce the chance for pleasure over the long run. Not many of these women develop insight. They do not think of themselves as "changing"; just of getting what they want in a smarter way. If her behavior has changed, one should not insist that her words change, too.

The mentally retarded mother

Another group of concern to caseworkers includes those mothers whose inadequacy stems from below-average intelligence. Not only is the care the retarded mother gives her children pervasively poor, but she herself is a limited target for casework treatment. How can we help?

In the field of mental retardation, confusion arises because terms are bandied carelessly about and generally misunderstood. We talk of feeblemindedness, mental deficiency, mental subnormality, mental retardation or borderline retardation as if they are synonymous. Even if the terms were used precisely, one cannot apply them to draw conclusions about a mother without considering what she is actually doing or not doing for her children.

From those who have done extensive psychological testing of mothers in poverty families, we have learned that the average IQ of such mothers falls typically in the borderline range of 68 to 83. In our own study of the self-supporting poor, the average IQ of the mothers was 79. Although this indicated that the thinking capacity of many -- by no means all -- was severely limited, we found that the quality of the care given the children does not seem to be grossly affected until the mother's score drops below 70. Inadequate and neglectful care may be expected when the IQ of the mother is below 60.

The American Association on Mental Deficiency has given the following guidelines to estimated degrees of intelligence:

Borderline Retardation	IQ 68-73
Mild Retardation	IQ 52-67
Moderate Retardation	IQ 36-51
Severe Retardation	IQ 20-35
Profound Retardation	IQ below 20

Our discussion will be confined to mothers who fall into the categories of borderline, mild and moderate retardation. Within each group, abilities vary widely, and individual potentialities for mothering and learning must be assessed. But we are reminded again of the reluctance of caseworkers to look at the negatives among those they are trying to help. Often the worker assumes personal responsibility for the lack of progress and refuses to see a situation as inevitably irreversible. While making every effort to help her, the worker must maintain skepticism about how much his services to a retarded, neglectful mother can help the children. Such a mother may be able to learn simple tasks -- but adequate mothering is not a simple task.

Retarded mothers in the borderline range perform much like an average 10-year-old child. Those with greater retardation function at correspondingly younger levels of development -- even to preschool or kindergarten performance. Mothers suffering from emotional immaturity or conflict may sometimes give the impression that they are retarded. However, they score higher in the intelligence testing and may be spotted by caseworkers through the simple criteria suggested in the following section. On the other hand, mentally retarded women often have emotional problems and distortions similar to those of women of average intelligence. It is possible to be both retarded and emotionally disturbed.

Identification

Formal intelligence testing of all applicants as a criterion for service is neither tactful nor practical. However, clues are frequently available to help the caseworker assess the level of intellectual functioning of the individual client. School records sometimes include results from earlier testing. A history of placement in a special education program or a state institution for the retarded suggests limitations. Reports from family and acquaintances about a mother may alert the caseworker to the possibility that retardation is a cause of her difficulties. In that event, major life decisions should not be made about a mother and her family on the basis of presumed mental retardation. It is imperative and professionally ethical that valid, competent psychological testing be carried out.

Immature cognitive development manifests itself in a variety of ways. The following symptoms are not to be taken as definitive, but will alert the caseworker to the probability of retardation:

1. Illiteracy in women is almost invariably associated with significant mental retardation. Some retardates are able to read safety signs and simple directions, but few can comfortably read newspapers or magazines, instructional pamphlets, recipes or manuals on welfare rights. Most retarded women will be able to print their names and maybe a few simple words, but cursive writing, if they can do it at all, will be done slowly and awkwardly.

2. Some are able to tell time accurately, while others can tell time only to the hour or not at all. Calendars are confusing to many borderline retardates. For those with lesser ability, the seasons are judged by the weather or such activities as planting in the spring, raking leaves in the fall.

3. If the retarded mother can count and identify bills and coins correctly, this will probably be the limit of her skill in money management. She relies upon more competent people to assist her, and she depends upon the good will of merchants not to cheat her.

4. The thinking of the retarded person is almost always characterized by excessive concreteness and rigidity. That is, they have trouble seeing relationships between objects or events. They can focus their attention on only one thing at a time; they have "one-track minds."

5. Most retarded persons are able to travel over familiar routes, get about a small town, use the local shopping centers. However, the unfamiliar is frightening to them, and they must depend upon others to get them where they need to go.

With the development of centers for training and teaching retarded children, many of the retarded mothers coming to our attention have had schooling in one of these centers and have continued until they "aged out." Those who have had only public school opportunity will possibly get through the 6th grade, if social promotion is practiced. Often they will have stayed in school until they reached the minimal age limit of 16, and then quit.

A few borderline retarded women have held employment. They have been known to work successfully in routine, unskilled jobs such as packaging, simple assembly, or food processing. Frequently they are hired by other mothers as low-cost baby sitters. For obvious reasons, this practice should be discouraged. The retarded woman should also be discouraged from taking a job that is too complicated or involves skills that she can never acquire. Failure only adds to her long experience of frustration and discouragement.

Manual skill is not usual in the retarded women. She typically lacks the ability to operate or maintain complicated machinery or appliances. Washing machines, vacuum cleaners, sometimes even stoves baffle her. This accounts for the short life of labor-saving devices in her home.

Childlike and naive, these mothers are highly suggestible and easily influenced. They often are vulnerable to being exploited or cheated. One woman who lived with her baby in the home of her stepmother was made to do all the housework for a family of nine. Two retarded sisters, who lived together with their children, were good workers in a nursing home. When they applied for AFDC, despite an income of over $500 a month, it was found that each week they made payments on 14 insurance policies!

We see also manifestations of intellectual handicap in the recreation of the retarded. They seem to prefer activities expectable among grammar school children. "Mothers severely retarded are often found playing with dolls or coloring books, or engaging in other preschool hobbies.

The concreteness of thinking in the retarded woman leads her to have difficulty in making appropriate adult judgments. She is not likely to notice the early symptoms of illness in a child or to relate these to treatment. She cannot be relied upon to follow through on medical directions when the child is ill, nor can she anticipate dangerous situations.

> The children of Mrs. Jones were often exposed to hazards. Her 3-year-old son Philip was left to play barefoot in the mud puddles around the trailer home while all around him were jagged bits of metal broken off from rusty car fenders, and pieces of shattered glass. When her daughter Angie became seriously anemic, iron tablets had to be given by the Head Start teacher. Mrs. Jones could not remember to give the medicine daily. Moreover, she could not think of Angie as ill -- she was "just a little pale."
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> The Jones baby, an 18-month-old toddler, was found at home almost unable to breathe because he had packed bits of paper and food deep into his nostrils. His mother had not noticed. The Head Start teacher had also reported extensive body-rash on all the children from insect bites. Mrs. Jones said she wanted to get rid of the bugs and agreed to be home the next day when the man from the Health Department planned to exterminate. But the following day the trailer was locked, and no one was at home.

Etiology

An individual unfamiliar with retardation may picture a person with a physically distorted figure, with a disproportionately large or small head, misshapen skull, dwarfism or giantism, visual astigmatism, unsightly orthopedic conditions, and so forth. Such conditions are usually accompanied by permanent severe, organic impairment of the central nervous system. Women so handicapped are usually protected by life-long custodial care within their families, or they are placed in institutions. Rarely do we find one, nowadays, parenting a child.

The mother we see who is intellectually limited, therefore, often has the physical appearance of a normal adult. Her problem does not indicate great damage to the central nervous system. Such a mother was often not recognized as retarded until she started school. The exact cause of the retardation is often never established. More often than not, the poor, neglecting retarded mother is reflecting her own barren upbringing — poverty, lack of stimulation, limited opportunity for social interaction, and a series of self-defeating failures. She probably grew up with the kind of haphazard care she now gives her own children. Often she is herself a neglected child grown up, a product of cultural deprivation. In some instances, however, the social history will show that the mother began her own life as a premature baby, or with severe illness in infancy.

Among the mothers we see it does not matter greatly whether the retardation was due in the first place to a depriving environment, to poor heredity, or to central nervous system disease. By the time the retarded child is half-grown, her limitations become essentially less reversible. We cannot realistically hope that pouring in stimulation in adulthood will improve basic functioning. It will be too little; it is already too late. Our problem, rather, is to discover the limits of the mothers' abilities to care for their children, and try to help them reach these. The biggest thing we learn from trying to puzzle out the cause of the retardation is the desirability of not letting it go on to the next generation.

Effects on the Children

What happens to a child who is cared for by a Mentally Retarded mother? First his physical survival through infancy is precarious. Without the assistance of more adequate relatives or other adults, the retarded mother cannot meet the needs of the infant, whose very life depends upon regular nourishment and protection from cold and other dangers.

> Before Johnny Adams was 3 months old, he had been hospitalized five times with illnesses related to exposure and inconsistent care — pneumonia, malnutrition, etc. It seemed that Mrs. Adams, deserted by her husband before Johnny's birth, would not get up during the night to stoke the fire in the little wood stove that heated the drafty shack. The fire went out. She stayed warm under piles of old quilts, with no thought of the uncovered infant in his crib. She also could not remember to give him his bottle on any schedule. Johnny was wasting away, an example of "failure to thrive."

The retarded mother quickly forgets anything out of sight. A projected quick trip to the store can last for hours if she is diverted along the way.

> Little Bertha was placed in her playpen in the sun before Miss Ray left for the store. After all, the pediatrician had told her that the baby needed sunshine. Hours later a neighbor heard the whimpering of the suffering infant and took her to the hospital, where she required treatment for serious burns over most of her body. Miss Ray had been enjoying herself, drinking a soda, being with people in the neighborhood grocery store. She was never quite able to understand what had happened, since she was "just following doctor's orders."

Our concern for the child of the retarded mother increases as we learn more about the necessity of proteins in the development of brain tissue. If no thought is given to the child's nutritional needs, but he is fed at the whim of a child-mother, eating only the foods she likes, nourishment for his body and mind is a matter of chance. And the chances are poor.

The failure to provide food is matched by the retarded mother's inability to provide cognitive stimulation. We can expect a repetition of the cycle of school failure, social ineptness, and eventual retardation, not necessarily because of inherited characteristics, but because of environmental stimulus deprivation. Language development is likely to be slow. As the child grows older, his problems are likely to become increasingly serious as he lives from day to day with immaturity and child-like behavior of a parent who cannot function as an adequate model. The mother's own simplistic beliefs, superstitions, even her verbal expressions, become a part of his "education."

It is difficult, if not impossible, for the Mentally Retarded mother to become an effective influence on the behavior and character of her children as they grow older. Discipline is likely to be either nonexistent or harsh, inconsistent, unrelated to the behavior in question, and inappropriate to the child's age. The retarded mother's responses are rigid and usually reflect blind adherence to what someone has told her is right or wrong.

Treatment

Mentally Retarded mothers usually require some supervision in the management of their affairs, including child care. Sometimes this help is provided, more or less effectively, by their own parents or other more competent relatives. The caseworker needs to work with both the retarded mother and those who are exercising the supervision. There is a temptation to bypass the retarded mother and deal only with more competent relatives. But respect of the feelings of the retarded mother and involvement of her in plans are extremely important to success.

There are many retarded mothers who are trying to rear their children without help except that offered by the caseworker. One of the first requirements will be that workers understand early in the relationship what the diagnosis of mental retardation means with respect to the limits this imposes upon the kind of help such a mother can use and the rate of progress, if any, that can be anticipated. This is one situation in which it cannot be hoped that things will improve. Passage of time often means that the child is losing precious ground in his development.

Take, for instance, the earlier account of Mrs. Adams and Johnny. During the first few months of Johnny's life, the pediatrician telephoned the social services department, suggesting that a foster home be found for the baby. After much wheel spinning at the agency, Johnny became 6 months old and "didn't look neglected." He was being fed regularly, the same diet his mother had, biscuits, gravy and soda pop. Now, 2 years later, there is concern because Johnny has not said one word. He is a dull, lethargic child whose retardation may be irreversible. We are not suggesting that had Johnny been placed at 3 months of age he would become a whiz kid; but we are predicting that, being left with his mother, he will carry on the familial pattern of retardation.

The question of placement for children of retarded mothers should be considered as early as possible, not deferred in hopes that casework treatment of the mother will make such consideration unnecessary. Often the essence of casework, talking, cannot even be used effectively. The caseworker must develop skills to demonstrate what needs to be done, instead of talking about it. He must exercise authority firmly, but kindly. One never "suggests" to the retarded mother but one does say firmly, "This must be done, and this is the way to do it."

How can this be done without raising a solid wall of childish resistance and stubborness? We treat them as the children they are. They understand kindness, attention, simple language, one-at-a-time directions, honesty, praise and rewards. We must win their affection so that we can influence their behavior -- make them want to please us.

If the decision is made that the children are to remain with the intellectually limited mother, it must be understood that the caseworker's responsibility increases. Beyond providing basic necessities, he will be involved in many areas of the client's life, especially where the welfare of the children is concerned. Since money management is a chronic problem, these mothers need specific help in shopping for food, clothing, furniture — not just a demonstration trip, but routinely. Extreme cases of financial incompetency may require the appointment of a personal representative to control all expenditures.

The caseworker will have to arrange transportation for medical or other needed services if the mother must leave familiar surroundings. He will have to be responsible for the mother's keeping appointments at the right time on the right day. Generally, it is advisable to remind her of an appointment the day before, or even the same day, if possible. Relating an appointment hour to some routine in her life helps her to get ready on time — e.g., "I'll pick you up right after the school bus leaves with the children" has more meaning than, "Be ready to go at 8:30 in the morning."

Responsibility for keeping an eye on the medical needs of the retarded mother and her children can be shared by the caseworker and the health department. Regular visits by a public health nurse may be desirable to catch symptoms of illness early. The mother needs to be reminded by someone to get immunizations for the children as they are due. Constant check on what is fed and when to feed the children, especially babies under 2, will be one of the most important and difficult functions of the nurse or caseworker.

Clothing children is usually left to the discretion of the mother, if she is at all competent. But with the retarded mother there will be little awareness of when clothing needs replacing, and she will probably not have the ability to make alterations or repairs. She may be able to dress the children appropriately for the weather conditions, but even this should be checked.

One of the most helpful services to the retarded mother would be a homemaker, with understanding and qualifications to take over. Sometimes the homemaker can demonstrate domestic procedures. But we must accept the reality that the more retarded mothers will need constant supervision and their children will need a substitute mother until they are grown.

The greatest concern in regard to the retarded mother is the lack of emotional cognitive nurturance of her children. The earlier they can be exposed to more healthy, stimulating social and educational experiences outside the home, the better. Nurseries, Head Start (sometimes too late), day care centers, or any approved program the community has should be used to compensate for what the children miss from their mothers. The caseworker should help the older children become involved in recreational facilities, scouting, big sister or big brother organizations. The total community should be aware of, and when possible involved in, appropriate ways for helping the family.

Many communities have developed programs for the retarded adult, as well as for children. Some of these are purely social, while others offer training in self-help, grooming, hygiene and protection. The caseworker involved with a retarded mother and her family should become familiar with community resources, and even encourage the formation of groups to meet needs, if she has several women with this problem.

The mother in a reactive depression

An important point to clarify in assessing any new case of child neglect is how long it has been going on. If it represents a sharp change from the mother's usual behavior, it may tell us that she is depressed.

By the term "reactive depression" we refer to a cluster of feelings and behaviors that are morbid or unhealthy, reactions to the loss of a loved person, or to other kinds of traumatic life events. It is called "reactive" depression because it is in reaction to a specific external stimulus and is distinguished from depression that seems to arise from deep, longstanding processes within the person.

We in social work see a great many depressed people. This is because the amount of bad luck and traumata experienced by some of our families is almost unbelievable to those who have not shared their lives.

> Mr. D, age 46, had been an independent man, a skilled textile worker for most of his adult life. In the course of a routine physical examination, he was told that tests indicated he had tuberculosis, although the affected area could not be identified. Therefore, he could not return to his work. But, pending a definite diagnosis, he was not eligible for compensation, nor did he have a sufficiently well-defined disability to make him eligible for public assistance.
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> Mrs. D, 45, had been hospitalized for tuberculosis 12 years previously. In her, the disease was arrested but she remained frail and had difficulty holding a job outside the home while caring for three children.
>
> Adding to the strain imposed on the family by the sudden loss of income was the vagueness about Mr. D's diagnosis. Meanwhile he was subjected to a battery of examinations, including bronchoscopy, bronchograms and the like. A sense of impending disaster began to develop in Mr. D, a kind of anticipated mourning response. Desperate for income, he turned to driving a cab, concealing his doubtful medical history. One Sunday morning their 15-year-old son Larry, on a sudden impulse, decided to drive his father's cab to church as a prank. When Mr. D discovered the loss, he immediately notified the police, but Larry had already driven the car into a ditch.
>
> In this instance, the juvenile law worked swiftly and Larry was sent to training school. There disaster compounded disaster, like a Greek tragedy. While on work detail in the laundry, he either fell or was pushed into an open industrial washing machine and was killed. The father invoked a life insurance policy on the boy that was in good standing and made arrangements for the funeral. But before the boy's body had left the funeral home, the insurance company notified the Ds that "by virtue of an institutional placement, Larry was not a member of the household at time of death" and so no benefits were payable. The boy's body was transferred into a pine box provided by the county.
>
> A week after the funeral, Mrs. D. suffered a recurrence of tuberculosis symptoms that had been dormant for 12 years. Her weight dropped to 90 pounds; a bronchial cough and other respiratory symptoms developed; she began to cough blood. Yet all X-rays remained negative, and no physical basis for the symptoms could be established. Mrs. D went into a deep depression, refused to wear any clothing but her robe and slippers, and spent entire days in bed, as if back in the sanitorium. Mr. D sat on the couch in the living room, alternately immobilized by despair and raging against all authorities -- court, institutions, welfare workers, hospitals, doctors, insurance companies, and those he was convinced killed his son.

During this time, the two younger children were fed, clothed and kept in school by neighbors. Mr. and Mrs. D stated that they would just sit at home and die, since evidently the whole community just "wanted to kill them off." In one effort to seek redress, Mr. D went to the Juvenile Court. There he was told that some children are born good and others born bad, and Larry was just one of the latter. This did not seem to help him.

Normal Grief Reactions

Reactive depression is not to be confused with the varied but still normal ways in which grief can be expressed at the time of a shock, separation or death of a loved one. The free expression of anguish, self-reproach, irritation is to be encouraged at such times. Indeed, difficulty occurs when these feelings are not expressed, because such suppression distorts the normal process of grieving. Then the feelings may emerge much later, displaced and twisted, in the form of a stubborn reactive depression. Erich Lindemann has given us a comprehensive description of expectable mourning processes. These include such temporary, but only temporary symptoms as:

1. Bodily distress with disturbances in breathing, digestion and feelings of weakness and exhaustion. Tightness in the chest and literally a pain in the heart will be present.

2. Feelings of depression, with a sense of unreality and of emotional withdrawal from other people and events.

3. Intense preoccupation with images of the deceased.

4. Feelings of guilt about possible negligence, and regret that more was not done for the deceased person.

5. Temporarily impaired relationships to other people, with anger, irritability and hostility, and disorganized activity in general.

The resolution of grief in normal mourning occurs through what has been well called "grief work." We lean on the friends who come to call. We revive and live through again the memories associated with the loved ones we have lost. We go through the agonizing "work" of funerals, burials, disposition of effects, care of mementoes and photographs, settling estates and the like. Through release of feelings, through dependency on other loved ones, we express our grief. The completion of rituals gradually reassures us that we have been responsible and devoted. The pain of memory gradually recedes, and the attachment to the one we loved is loosened until it is relinquished. Thus, the wound is bound and heals itself. The grief, and its temporary depression, are said to be "self-limiting." Normally, that is, they clear by themselves.

But sometimes when a mother appears withdrawn and indifferent, she is overwhelmed and immobilized by despair from a loss no one has helped her to work through. She may still be responding to an event that happened long before, since many cases of reactive depression are left untreated and become worse. Of all the conditions we are considering in this book, this one is most likely to respond to casework treatment; and among our clientele depression is highly prevalent.

Identification

The Mother in a Reactive Depression may be immobilized; behavior that otherwise looks like indifference or apathy is actually severe reaction to loss of the loved person. Typically there is a persistent mood of despair and sadness; a sense of impending doom; slowing down of behavior and thought processes; some inability to concentrate, indecisiveness so that the client, by herself, is unable to seek help. Insomnia and "early waking" are the marks of mild depressions, as are often loss of appetite and constipation. Sometimes, however, the depression shows itself in more severe psychosomatic complaints such as asthma, colitis or other physical diseases triggered by emotional problems. Lindemann, again, gives us additional points to look for in identifying reactive depression;

1. Reaction to the life event may be delayed or postponed. The client seemingly retains her morale for weeks or months, but a reactivation may be suddenly precipitated by some other, less important, life happening.

2. There may be frenzied overactivity. Clients are also known who have adopted the symptoms shown by the deceased during his last illness, or they show other medical problems.

3. Withdrawal of attention to family and friends, and general social isolation often occur, accompanied by general loss of initiative.

4. There are outbursts of fury against specific persons, such as doctors and surgeons. Almost anyone who becomes deeply involved with the bereaved person becomes liable to attack, as her dependency on him reminds the mother of her dependency on the one she has lost.

5. Strong feelings of guilt and self-destructive behavior occur. Sometimes there is a suicide attempt. The mother may debase herself, seemingly deliberately, involving herself sexually with inappropriate men or refusing to "fix herself up" or being unwilling to "give herself the satisfaction" of enjoying a new dress, a hair styling, even a good home.

A good social history gives us many clues to identification of a reactive depression. In fact, the effort to get such a history from the client is often, in itself, useful therapy. To repeat, when a mother who had previously given good care rather suddenly shifts to slovenliness, we may well ask whether we are witnessing an instance of a person suffering from unresolved grief.

Etiology

We have been describing depression primarily as a reaction to loss of someone who is loved -- a dreadful life event that is vivid and understandable. Let us take note of two further considerations. First, loss of a loved person is, of course, not the only thing that triggers depression. Second, although terrible events can easily lead to depression, most people actually shake it off spontaneously rather soon, and go on. In other words, people vary in their ability to roll with the punches.

According to the classic explanation, depression is anger turned against oneself. The woman is hurt by some person or tragedy; the hurt leads to anger, an automatic response over which she has no control. She punishes herself out of guilt for being angry and as a substitute for pounding the person she cannot or dare not hit. One of the ways she punishes herself is by feeling badly; she also feels anxious for fear she will lose control and strike out in anger; and she is prone to downgrade and deprive herself as punishment.

Take the case of the woman whose husband has died. It is not uncommon to hear, among the tears, such recriminations as, "How could you go away and leave me?" Obviously, she is angry at the one who has deserted her. But this is a ridiculous feeling, to her adult mind, and also adds to the guilt she already feels toward the deceased person. It is no wonder, therefore, that it is so rare to find a bereaved person fully conscious of the anger they feel toward the one who has died. It is generally not easy to get the rage of depressed persons out in the open, and only highly skilled people should try. But the generalized irritability that so frequently accompanies depression is more understandable if we accept this picture of what goes on.

Of course, what makes the mother depressed is not the fact that she is so filled with anger and desire for vengeance. The depression comes from the fact that she is also a decent person, capable of feeling guilt, and reluctant to strike out at someone she has loved.

What are some other events that lead to depression? Drastic illness, a brush with death, is one. Under these circumstances, the woman who is ill faces the prospect of losing not just one person, but everybody! Depressions also occur in reaction to crippling mishaps, such as loss of a limb or disfigurement. It is possible to be in mourning for oneself -- "The me I used to know and love is gone." Consider the blow it must be to a man who has always enjoyed his strength to be afflicted with a chronic illness such as heart disease. One also sees depression in reaction to failure, with the implication that one is not much of a person. A deserted woman will say bluntly that she would have preferred that her husband died than that he left with another woman; the desertion is a blow to her self-esteem.

Why are some people more prone to depression than others? Part of the answer we already know from our discussion of normal processes of grief work. Those who can face their feelings and get them off their chests are better protected against lingering depressiveness. People who are ashamed of expressing feelings, who bottle up their emotions, are at a disadvantage. They pay a price for rigidity. For in bottling up the anger, they do something else they had not counted on. The anger remains suppressed, but so do the other emotions, such as joy and pleasure and loving. All that comes out is irritation with life.

Unwillingness to express emotions is partly dependent on the cultural background. There are many parts of the rural South, for example, in which demonstrativeness is more or less forbidden by the code. But even in nondemonstrative cultures, there are still noteworthy differences among families. It pays, therefore, to look into the family pattern. Sometimes we find that the mother has no reservations about letting her feelings out, but no one has cared enough to listen.

Effects on the Children

A mother suffering from reactive depression may expose her children to all the hazards of child neglect. When one mother was unable to leave her bed, even the physical needs of her children had to be assumed by her neighbors. Another woman, who took large amounts of medication and made recurrent suicidal gestures, so disregarded her youngsters that they had to be placed with relatives.

The underlying sadness in the depressive mother leaves her unable to communicate to her child feelings of joy, wonder, excitement, curiosity or even love. This gives him a legacy of constrictedness and guilt, if he identifies with his mother and takes over parts of her personality into his own. And, of course, a woman in a depression is in poor position to fulfill the role of mother. Some of the women we described as showing the Apathy-Futility syndrome were the products of unrewarding infancies because their own mothers, in turn, were depressed. A depressed woman cannot respond sensitively to her infant's needs because she is oblivious to his signals. She is also unable to offer the warmth and service all of us need to reassure us that the world is not such a bad place after all.

Older children whose mothers become depressed also show evidence of disturbance. The youngest child in one family went through a phase of restlessness and irritability in school at the time her mother was in her worst state. We should not lose sight of the need to help these mothers see that their children, too, need to learn to express feelings honestly. Nor should children be shielded from all suffering. This is not reality, either.

In many instances the child will have to be removed from his neglectful mother. And although she may be inadequate, she is the only mother he has known. Consequently, mourning reactions are to be expected from children who have had to be removed, even for their own good. Our openness and sympathy may help the child carry out the necessary grief work when the separation is still fresh. In that way, we have a better chance of warding off resentment and depressiveness that he might otherwise carry into his adult life.

Treatment

The treatment of reactive depression involves two major themes: ventilation and restitution. By "ventilation" we refer to helping the mother "air her feelings," get her grief and anger off her chest by expressing whatever seems to need expressing, even if it does not seem to her, or to us, to make a great deal of sense. Part of the treatment is already under way as we begin to learn what has been going on, and why she feels so badly.

By "restitution" we have in mind processes of making up to her for what she has lost. In the case of a death this is, of course, not literally possible. But it is true that one cure for losing a loved person is to find another. The caseworker, with his attentiveness, interest and concern, compensates in part for the loved person who is gone. Naturally, this is only a temporary arrangement. Our job is to help her over the crisis so that she can go on and hopefully find others with whom to make compensatory attachments. Restitution also includes making up for the hurts in other ways, as in the process of normal "grief work."

In the D family treatment consisted, first, of allowing for outpouring of all the anguish associated with such a horrible series of events. Once rational elements could be separated from the unreasonable, Mr. D was supported in seeking redress. As a beginning, the caseworker accompanied him to the state training school, where a sympathetic superintendent allowed him to visit the laundry and relive, step by step, the events leading to his son's death. They admitted blame in that no adult had been present while the boy was working around the huge, uncovered washing machinery. Mr. D located a lawyer willing to investigate his seeking legal redress for his son's death. The caseworker was also able to get state office intervention to clarify procedures so that public assistance could now be granted the family.

As Mrs. D became more able to talk, she revealed the accidental death some 12 years earlier of another son, then aged 3. He had been playing on the sidewalk when a car left the street and killed him. His mother had been ironing at the time and was filled with self-reproach for his having wandered unsupervised into the yard. The same feelings were triggered again, and this time she blamed Mr. D for not having fought the court harder to keep Larry out of the institution.

Mr. D was also angry with himself for allowing the judge to persuade him that Larry needed such stern disciplining. He had a grudge against his wife for having overprotected Larry, as her favorite child, feeling that this led to his prank. Both parents now were making comparisons between Larry, an A student, and a younger brother who seems slow, but who survived. So the depression into which Larry's death had sent them was a blow with a history that made it worse.

After months of grief work and steps seeking the righting of injustices that had been done, the Ds emerged with much of their original resilience. Mrs. D took a position as a practical nurse in a convalescent home, thus sublimating the sort of needs that led her to take to her own bed the year before.

More cruelty lay ahead for this family. The following year, Mr. D's condition was finally diagnosed as lung cancer, and he died in his wife's arms after surgery. A noted surgeon wrote a letter of great humility apologizing for the delay in diagnosis and the many difficulties Mr. D had undergone. This time, Mrs. D underwent a period of normal grief work. She is now operating at a mature level as a productive worker and a good mother. She refers many cases to the agency.

In this one case we see all the characteristic behavior patterns of reactive depression, including Mr. D's being in mourning for himself. We also see the roles that ventilation and active seeking of restitution can play in lifting the depression. As the depression resolved, child neglect ceased to be an issue and, in fact, this family became once more self-supporting.

Of course, in all of this it is well to bear in mind that the emotional part of the treatment takes place side by side with practical help. Let us reemphasize, therefore, how indecisive and immobilized many depressed mothers are when we first reach them. When a woman is in that state, it is often necessary to take hold of her life, kindly but gently making necessary decisions and carrying her along through necessary actions. Intervention by a relative may help. In a deep depression, psychiatric care will be indicated. But the mother will not be able to make up her mind to seek help in the first place, or choose where to go for it as her next step. In such a case, it is sometimes useful to point out to her that her inability to make up her mind is itself one of her symptoms — and what she must do to feel better. A depressed person with a history of good functioning most of her life has an excellent chance of improvement, given reasonably competent professional help. In persuading such a woman to take steps for herself (and her children) we can afford to be optimistic in our approach.

The psychotic mother

We come now to the last group of women whose neglect of their children stems from serious defects in their personalities. These are women who have one or another form of the serious mental disturbance referred to as psychosis. They are "out of contact with reality." Naturally a woman who is barely able to keep herself in touch with what is going on around her, who lives in a constant state of anger and fearfulness, a woman like this is in a poor position to offer her children competent mothering. There is a surprising number of such mothers. Not hospitalized, usually not so ill that they could be committed involuntarily, they are referred to as "ambulatory psychotics." Although it is true of only a minority, some psychotics are dangerous to their children, to themselves, and perhaps to their workers.

What Is Psychosis?

There are a number of kinds of psychosis. Two major groupings are disorders of thought and disorders of mood. In the mood disorders, depressions are extreme, or persons are constantly exhilarated and euphoric. In cases of thought disorders, there are confusion, incoherence, inability to follow a train of logic. Related to these symptoms is a loss of what is called "reality testing."

The key to a diagnosis of psychosis is whether there has been noteworthy loss of reality testing. When a person hears something or sees something that isn't there, he is hallucinating. This is a gross form of loss of reality testing. We also find delusional systems, as for example in the case of the isolated woman in a hill county who believes there is a worldwide conspiracy directed against her. Obviously in such people the ability to distinguish between what one is fantasying and what is really "out there" has been seriously damaged. Seldom, however, is reality testing completely gone in an ambulatory psychotic. Despite delusions, they often retain a good bit of practical sense that permits their moving around in the real world.

Identification

The diagnosis of psychosis takes specialized training and is best left to a psychiatrist if one is available. It would be inappropriate to encourage child welfare workers to attempt this judgment. It is necessary, however, to be alert to the possibility that the neglectful mother with whom one is dealing might be psychotic, in order that one can seek expert consultation or take whatever action seems indicated. Here are some symptoms that occur frequently, and that it is well to bear in mind:

1. *Social withdrawal.* This may show itself in marked shyness when around people, efforts to avoid social situations, or, in an extreme, staying by oneself all the time, like the mother who refuses to leave her bedroom.

2. *Loss of contact.* We see this, while interviewing, in the woman who seems unaware of what is going on around her, who drifts in and out of focus in her conversation, who seems at times to be staring aimlessly at a point far out in space. There is also the client who dashes around in disorganizaed fashion while with you. Silence is not the only expression of being out of contact, living in daydreams.

3. *Inappropriateness of mood.* One version of this is called "lability," in which mood veers wildly from sadness to hilarity

and back again, as with a perpetual adolescent. Another form is shown by the person who laughs in the midst of discussing something painful, or smiles vacantly in the face of bad news. Perhaps most frequent, however, is the patient whose mood is inappropriate because it never seems to change. It ranges from dull apathy to torpid stolidity. This is also called "flatness of affect."

4. *Bizarre behaviors and grimaces.* Sometimes the client will talk to herself, laugh at nothing at all — unless she is responding to inner voices! Strange movements with arms, legs, facial contortions and the like are worth noting.

5. *Disturbances in the stream of thought.* It is useful to note whether the client talks gibberish. Coining new words or using malapropisms is sometimes indicative that a person heretofore intact is breaking down. Some persons also show an inability to break off a stream of speech, repeating the same thing over and over like a record that is stuck; related to this may be a need to mimic everything they hear.

6. *Delusional systems.* These are sometimes hard to discern. Some of the distortions of reality are relatively mild. That is, we know that something is wrong, but is it wrong enough to indicate psychosis? A woman absolutely refused to have her son vaccinated so he could enter school. She was convinced that if he were vaccinated he would die. Forty or 50 years ago this belief was not uncommon among fearful mothers. But what does it mean now?

7. *Hallucinations.* Many clients are wise enough to refuse to admit having such symptoms except under highly skillful questioning. Therefore, we often infer the presence of hallucinations from bizarre reactions of the sort mentioned under point 4. The presence of hallucinations is ominous, of course.

8. *Severe anxiety* -- a kind of formless, chronic state of terror. Not all psychotics experience this, but most do. It is not true that psychotics as a rule have no insight and are unaware there is anything wrong with them. A great many can feel themselves losing contact; they regard their own symptoms as strange and frightening. Anxiety is both the cause and the effect of this illness. It shows itself in myriad ways.

As noted, it is not the job of the social worker to make a positive diagnosis. However, if he finds two or three of the foregoing features in combination, the client probably should also be seen by a psychiatrist.

The most common psychosis is schizophrenia. Its hallmarks are thought disorder, loss of reality testing and flatness of mood. One is also likely to see a person in a very severe depression, or as is said, "depressed to a psychotic degree" — disorganization and thought disorder, along with sadness and irritability. One characteristic of psychotic depression and of related manic states is the tendency for them to recur.

Finally, there is the person referred to as the borderline psychotic. Such a woman may show elements of various major psychiatric entities. At times she seems normal; at other times she may seem neurotic, psychotic, or to present a character disorder. It is hard to identify her because her fluctuating behavior is misleading. Only over a period of time, as we experience her relationship with us and observe her operate in the community, does a pattern emerge.

> Mrs. Dawn is 35 years old, separated mother of four. The older children generally stay with the father, the youngest child, with her mother. Mrs. Dawn is neat and clean in appearance and wears appropriate clothing. However, she uses too much makeup, dyes her hair a different color frequently, and looks garish or "brassy."
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> Mrs. Dawn applied for AFDC because her husband "deserted" her. She has never had a permanent or definite abode. She moves two or three times a year, making her home with relatives of friends until she has a spat with them and moves on. Wherever she lives she keeps the place and the children neat and clean, sometimes under very adverse conditions.
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> When she first became known to the agency, Mrs. Dawn was suffering from high blood pressure and was hospitalized for a circulatory disorder. Later she complained of being unable to sleep. She paced the floor constantly and expressed fear that her husband or family might break in and kill her. She reported that her husband had been begging to see her and had been sleeping in a shed behind the house. Mrs. Dawn called the police. When they arrived, "he scampered off."
>
> At one point Mrs. Dawn issued warrants for her husband's arrest for nonsupport. Mr. Dawn visited his wife and begged her to take up the warrants, showing her a doctor's statement that he was unable to work. A quarrel ensued when he refused to let her have the statement. Mrs. Dawn shot him in the leg with her gun and burned the doctor's paper. She then called the police to have him arrested for nonsupport. He did not press charges against her for shooting him, and he was imprisoned. A few

months later Mrs. Dawn had a fight with her father and sister. She scratched them so badly they required medical attention. Mrs. Dawn accused her father and sister of stealing her money, and threatening to send her to a mental hospital.

Mrs. Dawn has always been able to present herself, on superficial contact, as a well-organized person. She was adept at enlisting the sympathy and help of lawyers and other community people to intervene on her behalf with welfare, her husband, landlords, etc.

After their fight, her father was persuaded to sign a warrant for her commitment. Mrs. Dawn ran frantically, hiding when anyone approached. A report was received that she was trying to buy guns so that she could shoot the caseworker and the sheriff. One night she was cornered in her house by the sheriff, who sent for the welfare director to help take her to the hospital. The welfare director was hit on the head with a pop bottle. But they got her to a mental hospital in the area.

The Dawn children were taken by Mrs. Dawn's parents. Later their father was released from prison. He took the children with him to another community where he had found employment.

At the mental hospital, authorities said they could not legally keep Mrs. Dawn beyond her emergency commitment because they did not have enough evidence from psychiatric examination to prove that she was psychotic. Mrs. Dawn requested discharge, and it was granted after 20 days in the hospital. Needless to say, the sheriff, the agency director and the caseworker were upset.

Mrs. Dawn began a long court battle for her children. The 4-year-old daughter was returned, but Mr. Dawn continues to keep the three boys. Mrs. Dawn seems to have given up. She has taken up residence with a man who she says is her cousin. Like her husband, he sometimes beats her.

Since her release from the hospital. Mrs. Dawn shows more psychotic features and is probably a borderline psychotic. Her affect is often inappropriate — she giggles suddenly for no reason. While telling of her boyfriend's violence, she begins to laugh uncontrollably. Her thinking is disordered — she starts a sentence and finishes with the ending of another sentence irrelevant to the first. Her associations are loose. She continues to be extremely manipulative. She associates with several other paranoid persons in town and, together, they stir up sympathy for themselves and hostility toward the agencies that must deal with them.

It is the opinion of some psychiatrists that the borderline patient represents a clinical entity bordering on normality, neurosis, psychosis and psychopathy, containing elements of any or all of these. In fact, many now believe that the patient remains more or less at the same level throughout her life — stable in her instability.

Over the years, the borderline patient has been given a number of other designations — preschizophrenia, pseudoneurotic psychotic, and the like. These terms indicate the sense that under a shaky adjustment on the surface lies severe disturbance. Although she lacks the grosser symptoms such as hallucinations, delusions or far-reaching disorganization, and we do not find typically wild mood swings, there is an absence of normal feelings, an extreme underlying mistrust of others, much barely concealed anger and meanness, and invariably, confusion about her identity — her role in life.

One of the characteristic features of borderline patients is that, when hospitalized, they rapidly pull themselves back together, and seem to be, at worst, severely neurotic. If this pattern is not recognized, planning for the children will be greatly complicated, as with Mrs. Dawn.

Effects on the Children

When the mother is in an acute psychosis, the obvious and immediate danger is the safety of her child. From time to time, we read in the papers of a woman who has killed her children and then herself. Of course, most such mothers are psychotic. Fortunately, such things happen rarely. Usually, the psychotic mother is merely an example of the woman who has no idea her child is being neglected. Lost in her fantasies, she may forget for hours at a time to feed the children; she may use very bad judgment about keeping them up late while she pursues a man or a feud, or about exposing them to scenes of violence. That a child's personality can be damaged by such experiences and by identification with a psychotic parent is obvious.

Treatment

Treating a psychotic person in order to restore her to reasonably constructive functioning, with minimal chances of further breakdown, is a job for the most highly skilled therapist. It cannot be attempted under the conditions of child welfare work. Our task, rather, is to learn to recognize the illness when it exists in our client, and handle her in terms of it. Often this will require that her children be removed. But sometimes this cannot be arranged and sometimes it is not absolutely necessary. Therefore, the aim is to help the woman to be the best mother she can despite her illness. Following are some suggestions.

A cardinal rule in working with the psychotic mother is not to become involved in exploring her hidden fantasies or in making guesses about her unconscious motives. There is danger that interpreting motives of which she is not already aware will lead to further deterioration or a breakdown. Many such women have a need to carry on tirades, so the worker will have to think through his policy in dealing with them. It is all right to listen sympathetically, at least for a time; it is often definitely not appropriate to argue with her or try to show her where she is wrong. But neither must one support her delusions. When she demands, "Don't you agree?", one can answer, "Well, I certainly know this is how you feel because you've just been telling me." In other words, in dealing with an argumentative person, one can remain sympathetic while steadfastly refusing to join in her distortions.

As much as possible, the caseworker's task is to focus on issues that are current, concrete and need to be solved. One avoids generalities and symbolism in favor of, "How do you suppose we can get him ready for school on time?" There are two reasons for this approach. The first is to help this mother retain and strengthen her capacities for dealing with her real life, right now. Even more crucial, however, is the protection of her children. In the drama and excitement a psychotic mother can stir around her, it is possible to be diverted from this fundamental child welfare interest.

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The Impact of Abuse and Neglect upon the Child

Recognizing and understanding physical, psychological, and social effects of abuse and neglect on child development

Training Program in Child Abuse and Neglect: Needs of Children

Summary

Jane K. Ives, Ph.D.

This presentation includes two parts, (1) a summary of the effects of deprivation and (2) a review of the developmental tasks of childhood.

Although the effects of deprivation on children have been recognized for centuries, it is only during the last forty years that hundreds of studies have accumulated evidence of these effects in some orderly fashion. Some have frowned on neglect and abuse, others on delinquency, separation from a caretaker, learning disabilities, concentration camps, social stigma, and institutionalization. An extensive review of this literature "Perspectives on Human Deprivation" identified characteristics of persons who have been deprived as tending to be defective in the development of (1) imaginative capacity, (2) strong affectional systems, (3) achievement disposition, (4) self-esteem, (5) social role acquisition, (6) moral idealogy, and (7) interpersonal competence.

Imaginative capacity is a cognitive skill essential to the development of effective problem solving abilities. It supports the development of interests and diminishes the potential for assaultive behavior. In homes where conditions are crowded, where mothers have little energy to play with children, activities providing interaction with an adult are not available. There is little opportunity to develop interest in reading and little stimulus for imaginative play. In a chaotic family, opportunity for the privacy and quiet necessary for developing the skills of speculation and imagination are lacking.

A *weak affectional system* follows neglect. Poor relationships with parents stifle the development of a strong sense of identity and poor peer relationships follow. Stigma for whatever reason interacts with low self-esteem to inhibit the development of sound interpersonal relationships.

A *definite achievement disposition* correlates with restricted life space, absence of creative toys and reading, devaluation, a sense of alienation from the mainstream of society. For persons who have been devalued and who have little hope that their performance will be successful, there is little motive for work and for a future orientation.

Low self-esteem is a persistent and marked characteristic of those who have suffered deprivation. Neglecting parents do not provide sound role models and do not set the limits which provide a safe environment for a child to experiment and to achieve. Low self-esteem is damaging to interpersonal competence, to emotional comfor- and cognitive development. For those who lack self-esteem, failure is a self-fulfilling prophecy.

The deprived rank low in *social role taking.* Major social roles include worker, marriage partner, parent. Adequate role models are often missing from the milieu of the deprived person. Prerequisites for development of adequate social roles are accurate perceptions of these roles, understanding of role behavior, motivation to adapt them and a learning environment that supports effective role development.

The development of *adequate moral ideaology* is associated with ego strength. Thus those whose early experience inhibits the achievement of developmental tasks are handicapped by their lack of capacityl to delay gratification and by lack of self control.

Poor *interpersonal competence* is associated with lack of empathetic capacity. The tactics of getting what one wants from others are learned early in life and the deprived have been frustrated in this respect. A nice capacity for flexibility, some trust in society and control are likewise prerequisites of interpersonal competence.

Understanding the characteristics of deprived children is one aspect of understanding children's needs. The other side of this coin is understanding the prerequisites for successful development. Erickson has presented a sequence of social tasks the achievement of which are necessary for the integration of personality.

These stages of preadolescense are:

1. Infancy. The achievement of trust as against mistrust and the development of the strength of hope.

2. Early childhood. The development of a sense of autonomy versus shame and doubt and the development of the quality of will.

3. Preschool years. The development of initiative as against a sense of guilt and the acquisition of a sense of purpose.

4. School age. The development of a quantity of industry as against feelings of inferiority and the achievement of competence.

This framework has been used by many experts in child development to elaborate on the physical, emotional, cognitive and social aspects of child rearing. It is a particularly useful framework for social workers in their ongoing study of individual behavior because it focuses on the interface between the person and his society, particularly his family. Competent parents support the child's growth toward independence from the adult for coping and thus gain satisfaction for themselves. The incompetent parent discourages the development of personality differentiation and coping skills, thus triggering a vicious cycle in which increased demands of children create an increased sense of parent's frustration.

"Balance" is the best one word clue to meeting the needs of children. They need stimulation and rest; limits for safety and encouragement to venture; consistent discipline and encouragement to develop their own decision making capacity; a predictable environment and exposure to new experience.

Being a competent parent is difficult, and perhaps it is more remarkable that most people succeed in this role, than that some fail. Certain behavioral patterns have been consistently identified as relating to parental failure, however, no one style of parenting is common to success.

Children's Play Characteristic of Different Ages

Arnold Gesell, M.D., Frances L. Ilg, M.D. and Louise Bates Ames

Growth Gradients

1. General interests

1 Year — Reciprocal nursery games as, "Where is baby?"
Gross motor activity
Putting objects in and out of other objects.
Play with buttons attached to a garment.

18 Months -- Climbs; moves furniture.
Plays with pull toys, dolls, teddy bear, pots and pans, balls, hammer toy.
Plays with sand, fills and empties containers, likes to pour it.
Blocks: carries around room, pounds together, builds tower of three or four.

2 Years -- Feeds and toilets doll, teddy bear; takes them for rides in carriage.
Plays with sand and/or water, filling dishes and then emptying them.
Pushes wagon or carriage.
Plays with little cars, screw driver, egg beater, little objects (pebbles, beads, bottles).
Some painting, finger painting, play with clay.
Blocks: lines them up or uses them manipulatively to fill wagons. Likes colored blocks or blocks which fit into each other.
Christmas: chiefly the tree is important. Some interest in presents.

2½ Years — Domestic play with doll or teddy bear and housekeeping toys.
Plays with cars or wagons.
Sand and water play, makes pies and cakes with sand or mud. Tea parties with mud cakes and water tea. Soap bubble play.
Paints with some design. Finger paints.
Makes pies or cakes of clay.
Blocks: vertical and horizontal building; names structures; may use large blocks as coal and lumber.

3 Years — Rides tricycle; pushes wagon, fire-engine or train.
Swings, plays on jungle gym.
Domestic play (both girls and boys) with doll, teddy bear and household equipment.
Plays with imaginary playmates.
Plays house, store, train with other children and simple equipment.
Colors with crayons as well as paints. May draw simple figures.
Plays in mud or sand; makes cakes, pies, roads, tunnels. Combines with other materials.
Blocks: builds structures, using a diversity of shapes and sizes. May combine blocks and train. Enjoys construction more than play with finished product.
Christmas: interest in Santa Claus; in presents he receives.

4 Years -- Prefers to play with other children. Dramatic play of house, store, train, hospital, involves costumes and "props." Combination of real and imaginative.
Rides tricycle; climbs, does "tricks."
Plays with imaginary companions.
Draws, paints, colors.
Admires own products whether of clay, paint, paper, blocks.
Blocks: makes detailed constructions. Combines with furniture for dramatic play. Builds cooperatively with others.
Christmas: asks for specific presents, then brags about size and amount. Strong interest in Santa Claus.

5 Years — More independent play and likes to play indoors or out according to season or weather. Likes to have an adult nearby.
Much play centers around a house. Builds house with large blocks or with draped furniture. Plays house imitating adult activities.

From pp. 366-370, "Children's Play Characteristic of Different Ages" in THE CHILD FROM FIVE TO TEN, Arnold Gesell, Frances L. Ilg and Louise Bates Ames, Harper & Row, 1946.

From pp. 432-434 in YOUTH: THE YEARS FROM TEN TO SIXTEEN, Arnold Gesell, Frances L. Ilg and Louise Bates Ames. Copyright @ 1956 by Gesell Institute of Child Development, Inc.
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Plays with dolls using them as babies.
Child runs, climbs, swings, skips, jumps, dances.
Rides tricycle, pushes cart.
Tries roller skates, jump rope, even stilts.
Uses sand in making roads, transporting it in cars.
Imitative play: house, store, hospital.
Paints, draws, colors, cuts, and pastes, and does puzzles.
Copies letters and numbers.
Games of matching pictures and forms.
Builds with blocks, large and small. Likes to copy designs with blocks.
Christmas: asks for specific presents. May request things by a letter to Santa Claus. Anxious to tell what he has received. Strong belief and interest in details about Santa Claus and in visiting him.
Girls Doll play, playing house, dressing up.
Boys Blocks, tools, cars and trucks, war games, mechanical toys.

6 Years — Elaborates and expands five-year play interests.
Mud, sand and water play.
Games of tag, hide-and-seek; stunts on trapeze, on rope and on tricycle.
Ball play: tossing, bouncing, throwing.
Rough and tumble play, climbing, swinging.
Interest in roller skates, double runner ice skates.
Simple carpentry: hammering, sawing.
Table games with cards ("Go Fish"), anagrams, dominoes and puzzles.
Paints, colors, draws and uses clay. Cuts and pastes.
Collecting odds and ends.
Printing letters to spell real words.
Games of oral spelling or oral numbers.
Imaginative play: pretending to be a horse; pretending furniture is a boat, etc.
Blocks used imaginatively and constructively.
Christmas: may want specific toy (doll or train) and be disappointed if it is not received, but also wants many presents. Boasts and brags about how many received. Strong interest and belief in Santa Claus.
Girls Doll play elaborated with dolls' accessories: clothes, suitcase, furniture.
Dressing up in adult clothes.
Playing school, house, library.
Boys Tinker toys and simple erector sets.
War games, cowboys, cops and robbers.
Digging holes and tunnels and simple activity in garden.
Interest in transportation using wagon, trains, trucks, airplanes and boats.

7 Years — More intense interest in some activities, fewer new ventures.
Has "mania" for certain activities: guns, funny books or coloring.
More solitary play.
Some play with mud, and digging, and some interest in garden tools.
Magic and tricks. Jigsaw puzzles.
Collecting and swapping cards, bottle tops, and stowing away stones and bits of this and that.
Interest in swimming often strong.
Plays library, train, post office with elaborate paraphernalia.
Rudiments of ball play: "catch," batting with soft ball.
Christmas: very great disappointment now if does not receive a requested toy. Writes letter to Santa Claus with list of desired toys.
Girls Cutting out paper dolls and their clothes. Doll play may decrease. May "invent" dresses for dolls.
Playing house which includes dressing up in elaborate adult costumes.
Playing school with emphasis on teacher role.
Hopscotch and jump rope, roller skating, ball bouncing.
Boys Active outdoor play of running, wrestling, climbing trees.
Carpentry, especially sawing. Like to make Christmas presents.
Rigging things from cereal boxes, etc.
Make paper planes and shoot them; make model airplanes.
Cops and robbers, commandos, gun play, war play.
Building and playing in tree houses, forts, huts and tents.
Beginning interest in chemistry, telegraphy, navigation.

8 Years — Variety of play interests. Prefer companionship in play (adult or child).
Games of all kinds played indoors or out. Differentiate work from play.
Table games of parchesi, checkers, dominoes, card games. Jigsaw puzzles and map puzzles. Scorns too simple games. May make up own game with own rules.
Dramatic play of giving shows. Arranges and produces these shows.
"Gadget" age. Likes to have variety of things and tries to make something of them.
Collecting and arranging of collections.
Beginning interest in group games such as soccer or base-

ball with supervision.

Unorganized group play of wild running, chasing, wrestling.

Beginning of secret clubs, usually short-lived.

Season interests: rowing and swimming in summer; skating, sliding, skiing in winter; playing with marbles, kites and tops in spring.

Boys and girls beginning to separate in play.

Christmas: has innumerable ideas of what would like for Christmas and wants are now intense. Interest in how many presents received. Do not want useful things. More interest than earlier in giving presents.

Girls Doll play and playing house, stressing more complex adult relationships. In make-believe play, child requires complete attention of companion.

Paper doll play: collects large number of dolls and doll clothes. Cuts out and tries on dresses. Likes to have them admired. Simple dramatic play with dolls involving much verbalization. Likes books with many different dolls.

Boys Beginning to utilize tools to fix things around house; make mixtures with chemistry set. Use telegraph to communicate.

Continue to work with airplane, train and boat models.

War games, cops and robbers, commandos.

Electric trains and movie projectors.

9 Years - Plays and works hard and is apt to overdo to point of fatigue.

Busy with own activities. Plans what he is going to do.

Individual differences stronger: some read and listen to radio more; others play outdoors more.

Some former interests may be dropped while others are intensified.

Coasting a favorite outdoor sport, but also marked interest in baseball, skating, swimming and other sports.

Interest in organized clubs such as Cubs and Brownies.

Spontaneous clubs are short-lived. Stress special interest in club house or hide-away.

Collecting of stamps, minerals, etc.

Hikes and goes for walks in woods.

Drawing maps, making lists of collections. Writing "business" letters in response to radio advertisements or from catalogues.

Playing more complicated table games.

Some have animals which they are supposed to care for.

Christmas: makes long lists of presents, not expecting to receive all. May understand that cost of presents may be too high or that they may not be procurable. Interest in number of presents and may classify them by size or type.

Interest in trimming own tree and in making ornaments for it. May do own Christmas shopping, buying presents for family and friends. Interest in what they give others and how much they spend for each.

Girls Paper dolls used in dramatic play. Identify themselves with dolls, playing out elaborate dramas. Like books with fewer dolls and more different costumes. Or may enact entire day's routine in doll play.

May show interest in manipulating puppets.

Put simple abilities in sewing and cooking to practical use.

Boys Constructing with mechano and erector sets and in workshop. May work with material for long period on a planned project.

Rough-housing and wrestling. Some are interested in boxing or gym lessons.

Beginning interest in bowling and horseshoes.

2. Reading

18 Months — Turns pages of a book.

2 Years — Likes to hear rhymes.

Likes tactile books.

Looks at pictures.

2½ Years — Likes to look at books alone; or to fill in last word as adult reads.

Likes rhymes or short stories about familiar subjects.

Enjoys books about transportation or animals: *Saturday Walk, Ask Mr. Bear.*

3 Years — Longer listening span.

Likes repetitive stories of familiar experiences, or imaginative books based on people and animals: *Caps for Sale, Little Black Sambo.*

Likes riddles and guessing games.

Stories must be re-read and re-told word for word.

Looks at books and may "read" to others or explain pictures.

Likes to look at colored advertisements of familiar objects in magazines.

Growth Gradients

1. Outdoor activities

10 YEARS

Bike riding very strong. Horseback riding (girls more than boys). Baseball, catch, throwing ball against house.

Sledding, skating, swimming.
Building or playing in "secret huts." Climbing trees.
"Pretend" games - may involve activity or be just verbal.
Running and hiding games.
Playing with and caring for pets and younger siblings.
Nature interests (in a few).

Girls Jump rope, roller skates, hopscotch.

Boys Racing-plain, bicycle, three-legged.
Cowboys, Wild West, just plain "guns." (Some are outgrowing this.)
"Just fooling around," "wrassling."

11 YEARS

Bicycling, Horseback riding (girls more than boys).
Hiking, walking in the woods. Nature interests. Pets.
Dodge ball, tether ball, kickball.
Seasonal sports (boys more): baseball, football, basketball. Some tennis.
Skating, skiing, swimming. Some sailing.
Running and hiding games (still, in some) — especially in big fields, vacant lots, woods.

Girls Remnants of roller skating, hopscotch, jump rope.

Boys Building hideouts or tree huts.
Fishing and hunting. Some gardening
Remnants of cops and robbers, Wild West.

12 YEARS

Many "just hang around" or "just fool around."
Swimming, sailing, skiing, skating, sledding.
Bicycling. Horseback riding (girls more).
Remnants of hide-and-seek, running games.
Helping in yard or garden (some enjoy this).
Walking in woods. Interest in nature. Pets.
Spectator sports.

Girls Croquet. Non-athletic girls now losing interest in sports.

Boys Climbing trees, tree forts. Hunting, shooting, fishing.
Seasonal sports: baseball, football, basketball, hockey.
Tournaments: tennis, badminton, boxing, bicycle races, fencing.

13 YEARS

Baseball. (This is declining in girls.)
Swimming and sailing. Skating and skiing. Tennis.
Horseback (declining).
Pets.

Girls Walks or bicycle rides with friends. "Boys and baseball."
Outdoor interests are narrowing down more than boys' interests. Sports nearly out except with the athletically inclined.

Boys "Wrapped up in sports" — basketball, football, hockey, all other kinds.
Hunting, fishing, shooting.
Shoveling snow, raking leaves (enjoyed by some).
Golf and caddying
Imaginary ballgames (played alone).

14 YEARS

"Hacking around."
Baseball — playing or watching.
Skating, skiing, hockey, sledding. Swimming and sailing. Tennis.
Bicycling and horseback riding (girls most for both).
Spectator sports.

Girls Walking (mostly to store, movies, friend's house).

Boys Some just say "sports." Football, basketball, golf.
Hunting, fishing, shooting.
"Fooling around" with automobiles, supervised driving.
Yard work.
More different outdoor activities than girls.

15 YEARS

"Going places with friends" — movies, beach, coke places. Dating.
Basketball or baseball. Swimming. Skiing.
Watching games.

Girls Horseback riding (less than before). Walking in woods.

Boys "Any sports." Football, hockey. Hunting, fishing.
Driving (under supervision), "hacking around" in friend's car.
More different outdoor activities than girls.

16 YEARS

The usual sports — baseball, basketball, swimming, tennis, sailing — in those who now care for sports.
Taking walks, going for rides.
Watching sports events.

Girls Shopping. Horseback riding.

Boys Shooting. Hunting and fishing. Golf. "Just hanging around." Driving.

2. Indoor activities

10 YEARS

Collecting: stamps, coins, china animals, dolls, postcards, trading cards, model airplanes, stones, shells, nature specimens, boxes, box tops.
Card and table games. Jigsaw puzzles. Scrapbooks.
Entertaining, especially reading to, younger siblings.

Pets.
Secret clubs.

Girls Doll-play — playing house, sewing for dolls. Creating paper dolls. Drawing, painting, ceramics. Writing stories or plays, then dressing up and acting them.

Boys Drawing, designing, creating or imagining gadgets and inventions: secret rooms, jet rockets or planes, boats, etc.
Constructing model planes. Erector sets. Electric trains. Chemistry sets. Beginning interest in photography.
Disdain is expressed for outgrown activities.

11 YEARS

Huge collections: stamps, coins, postcards, trading cards, baseball cards, horse models, china animals, dolls, shells, stones, birds' nests, boxes, model boats, toy guns.
Card games, table games, puzzles.

Composite Developmental Inventory for Infants and Young Children

Equipment needed for each age level:

4 months - pencil
6 months - cup, toys (spoon, tongue blade, etc.), mirror
9 months - test-tube, corks, toys
12 months - toys, cup corks, metal or paper pillboxes or blocks, pencil erasers, narrow neck bottle which will admit pencil erasers, pencil, history-size paper, picture book as used for coloring.
24 months - picture book
30 months - pencil, paper

Developmental Inventory*

1 month - Briefly follows moving stimulus.
Regards examiner's face momentarily.
Holds head erect briefly when supported in upright position.
Avoidance of mildly annoying stimuli, e.g., cloth lightly placed over face.
Lifts head slightly when prone.
Quieted when picked up.

2 months - Head erect with bobbing when supported in sitting position.
Eyes follow moving person.
Vocalization other than crying.
Smiles at times.

3 months - Eyes follow moving objects in all planes.
Searches for sound with eyes.
Lifts head and chest when prone.
Vigorous body movements.
Anticipates feeding upon sight of bottle with activity change or movements of mouth.
Cooing and chuckling.

4 months - Grasps pencil with both hands and holds briefly.
Follows moving object when held in sitting position.
Enjoys play activity.
Rolls from side to side but not completely over.
Initiates smiling and laughs aloud.

6 months - Sits with minimal support with stable back and head.
Lifts cup.
Attempts to attain toy held beyond reach.
Responds to image in mirror.
Exploits possibilities of play material, e.g. hand-to-hand transfer, banging, transfer to mouth, etc.
Rolls over, supine to prone position.
Babbles in more than two distinct sounds.
Differentiates strangers from family.

9 months - Uses thumb to help grasp tiny objects.
Holds and manipulates two objects at a time.
Sits alone and can change position without falling.
Says "mama" or "dada."
Plays interpersonal games like peek-a-boo and pat-a-cake.

12 months - Hands toy to examiner when requested to do so.
Puts small objects (e.g. test-tube cork) in and removes them from cup.
Will retrieve hidden toy (under box, cup, or cloth).
Stands with support and takes steps when supported.
Words (two or three in addition to "mama" and "dada."
Gives affection.
Holds cup with assistance for taking fluids.

15 months - Can stack two pillboxes or blocks one on top of the other.
Can imitate placing small object into small bottle (e.g., aspirin-size object into bottle) and if demonstrated can "pour" object out of bottle.
Can scribble by imitation.
Walks without support.
Climbs onto stairs or low chair.
Uses about five words.
Shows interest in picture books.

18 months - Walks well and runs a bit.
Can seat self and climb into chair.
Can walk with pull-toy.
Can go up and down stairs.
Likes to be read to and interested in books with pictures.

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*Underlined items may be observed or reported by parent.

From Mental Retardation: A Report of the American Medical Association Conference on Mental Retardation, April 9-11, 1964, 2nd edition, 1974, pp. 101-103. Reprinted by permission of the American Medical Association.

Bowel training reasonably established.
About ten words in vocabulary.
Handles spoon reasonably well and feeds self partially.

24 months - Can deal with a few mechanical contrivances, e.g. open a door, turn on faucet, etc.
Can identify a few pictures by name, e.g. dog, cup, kitty, train, car, baby.
Asks for things (e.g., food, drink, toilet) by combination of words and gestures.
Can throw or kick a ball.
Walks up and down stairs alone.
Sits and "reads" little picture books, turns pages by self.
Makes little two-to-three-word sentences.
Imitates household tasks.
Engages in play activities similar to those of playmate, i.e., parallel play.
Daytime bowel and bladder control established.
Identifies familiar objects seen on TV.

30 months - Can imitate vertical and horizontal strokes on paper.
Can fold letter-size paper in half to make a little book (demonstrated).
Can repeat two digits (4-7, 6-3, 5-8) read at rate of one per second.
Can walk on tiptoe (demonstrated) and stand briefly on one foot.
Relates experience in simple language.
Can tell name and age (if taught).
Uses pronouns.
Helps to dress and undress self.
Perceives certain dangerous situations: not likely to walk into moving swing, aware of street as danger zone, etc.

36 months - Can copy a circle reasonably well.
Can repeat three unrelated digits (one correct out of three trials).
Can relate what produces certain actions, e.g., barks, meows, flies in the sky, gets hot, shoots, swims, cuts, sails, etc. Any appropriate answer acceptable.
Knows last name when asked by examiner.
Handles most of dressing, including shoes and accessible buttons.
Goes up and down stairs, one foot on each stair.
Can be trusted in room alone for short periods.
Can ride tricycle using pedals.
Can understand sharing and taking turns.

(This inventory is modified from Caldwell, B.M. and Drachman, R.H.: Comparability of Three Methods of Assessing Developmental Level of Young Infants, Pediatrics 34:51-57 (July) 1964.) Another convenient developmental screening instrument has been developed by Dr. Hilda Knobloch and can be obtained by writing directly to her at the Children's Hospital, Columbus, Ohio.

When to Suspect Child Abuse

Vincent J. Fontana, M.D., F.A.A.P., Chairman,
New York City Task Force on Child Abuse and Neglect

The problem of assault and battery of children grows worse, not better. And while it's difficult and distasteful to accept that parents' maiming of children is becoming commonplace, nevertheless, family physicians must learn to be suspicious. Because it is what's happening. And two MD's recently lost a large lawsuit for failure to diagnose "assaultive parents."

Deaths from all types of accidents account for nearly twice as many deaths as cancer, the leading cause of childhood deaths. It has been suggested that many of these accidental deaths may well be due to undetected and unreported parental abuse.[1] Dr. C. Henry Kempe, the pediatrician who in 1962, coined the term "Battered Child Syndrome,"[2] has estimated that at least 700 children are killed every year in this country by their parents or parent surrogates. Thousands more are permanently injured, physically or mentally, leading to the future battering parents and hard-core criminals in our society. The abused or neglected child is seen in all strata of society, rich and poor. The maltreatment of children is a disease affecting the child and parent. It is preventable and easy to recognize, if one thinks of it.

The neglect and abuse of children denotes a situation ranging from the deprivation of food, clothing, and shelter, and parental love to incidences in which children are physically abused and mistreated by an adult, resulting in obvious physical trauma to the child and often leading to death. The term applied to this clinical entity is that of the "maltreatment syndrome" in children.[3] The maltreated child may present itself in the physician's office with no obvious signs of being battered but may have a repressed personality, irritability, and other minor physical evidences of emotional deprivation and, at times, have nutritional deficiencies, "failure to thrive," malnutrition, anemia, poor skin hygiene, and other signs of insidious neglect. In such cases, think of the possibility of maltreatment, for early diagnosis can prevent the more serious injuries of inflicted trauma that are significant causes of childhood deaths.

The more seriously abused children are, of course, seen in hospital emergency rooms, with external evidences of body trauma, dislocations and fractures of extremities associated with neurological signs of intracranial damage, bruises, lacerations, cuts, burns, and hematomas. Unexplained episodes of acute rupture of an abdominal viscus, and hypernatremic dehydration following periodic water deprivation by psychotic mothers have been reported as forms of child abuse. Those with the most severe maltreatment injuries arrive at the hospital or in the family physician's office in coma, convulsions or even death.

There appears to be an increase in the number of reported cases of child abuse and neglect as mandated by child abuse laws now existing in every state in the country. In New York City alone, there were over 4,000 cases of child abuse reported to the New York Central Registry in 1971, more than a 500% increase in reported cases within the period 1966 to 1970. It has been estimated that less than 1% of these cases were reported by private physicians. Dr. Edmund Joyner, in a symposium on child abuse,[4] indicated that the practitioners' low reporting rate is probably due to the physician's failure to recognize abuse, through ignorance of its manifestations or their refusal to do so through fear of becoming involved in time-consuming legal processes.

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From "When to Suspect Child Abuse", Vincent J. Fontana, M.D., Medical Times (October, 1973), pp. 116-122. Reprinted by permission of Romaine Pierson Publishers, Inc.

There are child abuse reporting laws in all 50 states mandating physicians to report to the appropriate child protective unit or the law enforcement agency any case of suspected child abuse and neglect. These laws are aimed to protect the parents when presented with invalid evidence; to protect the child from further injury; and to protect the physician from possible damage suits by the parties involved in any legal action.

Physicians have a moral and legal responsibility to report all *suspected* cases of child abuse and neglect that comes to their attention. They must, therefore, have an acute awareness of the problem, be suspect on behalf of any child who shows signs of questionable neglect or abuse and know the diagnostic criteria (see Table) necessary to confirm suspicions. The physician must protect the child not only by reporting the case but by the prompt removal of the child from a life-threatening environment.

What to look for

The diagnosis of the maltreatment syndrome in children can be easily made, especially by the physician who is able to recognize situations in which abuse or neglect may exist. It is not necessary for a doctor to be absolutely sure about an abuse or neglect case, as the law clearly states that cases of suspicion must also be reported. The physician's index of suspicion includes a number of signs and symptoms. It should be remembered, however, that not all the signs are physical. Much of the diagnosis is dependent on the correlation of the clinical history and the findings on physical examination. In the history, it will often be noted that the parents relate a story that is at variance with the clinical findings. The parents will often take the child to various hospitals for multiple visits in order to stem off any suspicion on the part of hospital authorities. There is often evidence of family discord, financial stress, alcoholism, psychosis, perversion, and drug addiction noted in these abusing parents. When questioning the parents, they are often reluctant to give any type of information and oftentimes it is noted that there has been delay in seeking medical help. There is a certain inappropriate reaction on the part of the parents to the severity of the injury and the condition of the child.

On physical examination, there may be signs of general neglect including poor skin hygiene, malnutrition, anemia, and evidences of "failure to thrive." A withdrawn, irritable, repressed personality is often seen in a child who has been the victim of repeated abuse and neglect. There may be bruises, abrasions, burns, soft tissue swellings, hematomas, and evidences of old healed lesions. Dislocations, bone injury and fractures may at times be associated with neurological signs of intracerebral damage.

Difficulty is often encountered in obtaining any type of history from the parents. The diagnosis, therefore, becomes dependent on physical examination, the x-ray findings, social service investigation, and a high index of suspicion on the part of the practitioner. Any child presenting with signs and symptoms that indicate abuse and neglect should have a complete x-ray survey including long bones and skull. X-rays of the battered infant's bones may show previously inflicted fractures presenting in various stages of healing. Oftentimes if the child is seen immediately after the inflicted trauma, bone injury may remain obscure for the first few days after infliction. In these cases, bone repair may become evident days after the inflicted bone trauma. For this reason, x-rays should be repeated approximately 5 to 7 days after the suspected trauma in order to ascertain the presence of diagnostic radiologic findings. Fortunately, there are specific x-ray findings related to trauma in the bones that are diagnostic. The unusual bone changes include metaphyseal fragmentation, "squaring" of the long bones, periosteal hemorrhages, periosteal calcification, presence of bone fragments, epiphyseal separations and periosteal shearing. These x-ray findings may be diagnostic when correlated with the history, physical examination, and social service investigation.

A diagnosis of the maltreatment syndrome, therefore, must encompass a complete physical examination of the child, a precise history, and the diagnostic x-ray findings that many times speak for the child. A differential diagnosis to rule out other organic causes of x-ray findings is essential before a definitive diagnosis is made. The differential diagnosis should include ruling out scurvy and rickets, infantile cortical hyperostosis, syphilis of infancy, osteogenesis imperfecta, and last but not least, the possibility of accidental trauma.

PHYSICIAN'S INDEX OF SUSPICION

HISTORY

- Parents often relate a story that is at variance with the clinical findings.
- Multiple visits to various hospitals.
- Familial discord of financial stress.
- Reluctance of parents to give information.

PHYSICAL EXAMINATION

- Signs of general neglect, poor skin hygiene, malnutrition, withdrawn, irritability, repressed personality.
- Bruises, abrasions, soft tissue swellings, hematomas, old healed lesions.
- Evidence of dislocation and/or fractures of the extremities.

RADIOLOGIC MANIFESTATIONS

- Subperiosteal hematomas
- Epiphyseal separations
- Periosteal shearing
- Metaphyseal fragmentation
- Previously healed periosteal reactions
- "Squaring" of the metaphysis

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"THE ONLY PROGRAM OF ITS KIND IN THE UNITED STATES"

While our government has done relatively little in the area of rehabilitation, nevertheless I feel optimistic that there are major inroads being made in formulating treatment modalities to combat this dreadful disease. I base my optimism on my findings as Project Coordinator of the New York Foundling Hospital's Shelter for Maltreating Parents, which emanated from the Mayor's Task Force on Child Abuse, of which Dr. Fontana is Chairman. Having been instrumental in developing this program, Dr. Fontana should be very encouraged that patients, for the first time in their lives, are formulating meaningful therapeutic relationships which are helping them to gain greater impulse control and a sense of self esteem.

The uniqueness of the Foundling's Shelter is that both the inpatient as well as the outpatient programs provide treatment to the victim, the child, as well as the parent inflicting abuse on the child. Living in a residence for three months, patients are observed on a 24-hour-a-day basis, whereby the interaction of mother and child is assessed. It is the only program of its kind in the United States, and patients can be admitted directly through the use of a hot line or by planned admissions. The program is comprehensive in nature, providing psychiatric, educational and social services over a period of one year.

The establishment of a meaningful, accepting relationship must be at the core of any treatment program if a patient is to be rehabilitated. This is particularly true of abusing parents since all evidence shows the vicious cycle of abuse from one generation to another has the underlying elements of rejection present. Our experience at the New York Foundling Hospital shows that despite the difficulty in establishing such a relationship, after a period of approximately four weeks when the patients test out the therapists' sincerity, such a relationship is established which greatly helps to prevent further abuse or neglect. I say this on the basis that abusing parents do, in fact, call upon the social worker or group parent in times of stress or depression which, in the past, were factors contributing to abuse or neglect. All of the social workers are under the supervision of professional personnel. They reach out to patients in their home, community or in the hospital. Their services include very practical approaches to problem solving, such as helping parents to talk out their problems rather than act them out, to use community resources, and the social workers also assist them in managing their households. One might say that to be successful in working with abusing parents, therapists--be they social workers, psychiatrists, pediatricians, etc.--must be willing to reach out to the patient if they expect to penetrate the wall which abusing parents build between themselves and those attempting to help them. It is of little surprise that such a wall exists when, in reviewing the histories of such patients, one will inevitably find that people representing authority, such as their own parents, have had a very negative influence on the personality development of these patients.

I feel that despite the complexity of the problem, we should be encouraged that inroads are being made, despite the fact that such programs are reaching only a small fraction of the total number of families in need. Hopefully, society will demand that such services be greatly expanded in the immediate future.

— Patrick D. Bologna, C.S.W., A.C. SW.
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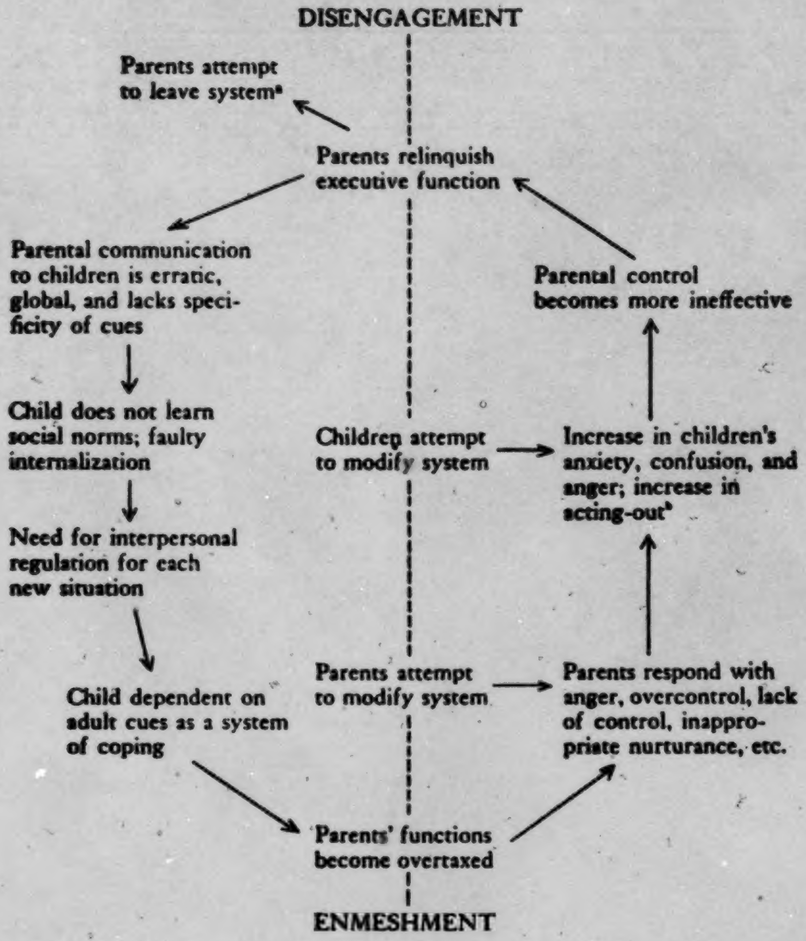
New York Foundling Hospital
Treatment Shelter for Maltreating Parents

Figure 1, "The Enmeshment-Disengagement System", from FAMILIES OF THE SLUMS: An Exploration of Their Structure and Treatment, by Salvador Minuchin, Braulio Montalvo, Bernard G. Guerney, Jr., Bernice L. Rosman, and Florence Schumer, (C) 1967 by Basic Books, Inc., Publisher, New York.

FIGURE 1

THE ENMESHMENT-DISENGAGEMENT SYSTEM


DISENGAGEMENT
Parents attempt to leave system[a]
Parents relinquish executive function
Parental communication to children is erratic, global, and lacks specificity of cues
Parental control becomes more ineffective
Child does not learn social norms; faulty internalization
Children attempt to modify system
Increase in children's anxiety, confusion, and anger; increase in acting-out[b]
Need for interpersonal regulation for each new situation
Child dependent on adult cues as a system of coping
Parents attempt to modify system
Parents respond with anger, overcontrol, lack of control, inappropriate nurturance, etc.
Parents' functions become overtaxed
ENMESHMENT

[a] When parental control becomes ineffective and parents relinquish executive functions, they may abandon the family altogether, but most of the time they segment the family by institutionalizing a child or children, acting-out (in illness, promiscuity, alcoholism, etc.), or allowing a sibling substructure to take over parental functions (see next section of this chapter).

[b] At the point of increase in the children's anxiety and acting-out as an attempt to modify the system, children may turn to the siblings for control, guidance, or identification (delinquent or not); they may abandon the family, e.g., run away; or they may join a delinquent gang.

The Client, the Worker, and the Community

The inadequacies of and remedies for interaction of the client, the social worker, and the community

Creaming the Poor

S.M. Miller, Pamela Roby and Alwine A. de Vos van Stienwijk

A lesson that we are still slow and reluctant to learn is that the question posed by poverty in this country is not, fundamentally, one of poverty but inequality. Most poor individuals in the United States do not experience the degree of suffering of Calcutta's homeless poor. Rather, most of the poor of the affluent economy suffer from lagging incomes; they are falling behind the rising standards of society. They are unequal. Nor can their inequality be calculated in narrow economic terms only. Current income is not the sole dimension of well-being. The neglected dimensions include not only other material markers like basic services and assets but more importantly, perhaps, the satisfaction, status and self-determination which differentially mark citizens.

Since the declaration of the poverty war, the United States has moved toward policies that seek to include more people in the services and opportunities open to the affluent majority of the population. But acts of inclusion also exclude. Efforts to improve the condition of the poor, when effective, generally result in improving the conditions of those at the top of the bottom, leaving the bottommost untouched. Those left behind may be worse off than before. Their relative deprivation may grow, or their feeling about themselves may become negative. The selective mobility of some may mean the selective debasement of many others. "On the dark side of every conception of 'opportunity' lies an equal measure of exclusion and rejection," wrote Peter Schrag. The poor are not an undifferentiated mass; their conditions and outlooks vary widely. We must become aware of their range of reactions to various kinds of interventions and programs.

The process by which mainly the least poor are included in poverty programs we in America have called creaming. Why does creaming occur? One answer might come from looking at the supposedly disabling social-psychological characteristics of the poorest. Despite its popularity, we think that this interpretation is inadequate.

In this essay we want to show, first, that creaming is a prominent result of most social policies intended to assist the poor and second, to explore why creaming takes place.

Organizational exclusion

Why and how do the very institutions that are nominally intended to include the excluded bar the most excluded of our society? The pervasive processes of selecting and excluding individuals may be viewed as a problem in the sociology of organizations. The conventional approach of organizational sociology concentrates on an analysis of the recruitment, selection and the behavior of staff and personnel. Our perspective differs in that we view the organization from the perspective of the low-income applicant, client or consumer. As the social services (in the broad sense of health, education and training services as well as social work and recreation) grow in this country, it will be increasingly important for social scientists to concentrate on the processes that influence the ways that organizational activities affect clients. Organizational policies and practices, frequently having nothing to do with individual applicants, largely determine who receives and who does not receive services. Persons who make and administer organizational policy select and process applicants on the basis of how they fit their own and their organization's needs and outlook.

Selection and exclusion of potential recipients occur at several points in the contact between agency and poor client. Clients who attempt to improve their well-being through the use of social services are confronted with four major steps: presentation, admission, completion and the aftermath.

Obtaining benefits from social services, then, is a matter of taking the hurdles. People must jump the obstacles, whether these are placed by themselves or by organizations, in order to obtain delivery of services. By schematicizing the process through which individuals move to and eventually gain benefit from services, we do not imply that there is necessarily a sequential development, for some of the steps obviously overlap. We believe, however, that it is worthwhile to make analytical separations in the process in order to see at what points it might be possible to improve the delivery of services. We are dealing with the twin processes of how the individual behaves and how the organization behaves. Let us look at the hurdles one by one.

Presentation

Erving Goffman has portrayed the many ways individual people present themselves and manage the impressions others form of

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them in everyday life. Similarly, we are interested in the way social agencies and programs present themselves to the public, especially the poorest of the poor. We are assuming, of course, the existence of services. Yet it's worth noting that many people are excluded from social services because they are not available in certain geographical areas or for certain ethnic groups. The poorest Americans live in predominantly rural areas, while most services and training programs are concentrated in urban and suburban areas. The inequality in the distribution of health services among various regions is particularly striking. New York state in 1966 for instance had 211 doctors per 100,000 population. Mississippi had 74. Los Angeles County had 127 physicians per 100,000 population; the southeast district of Watts had 38.

Three major questions are involved in the presentation of programs for the poor. First, who is notified of the program? Second, what impression does the program make on its audience? Third, is the program or service accessible to people who find it appealing and would like to participate in it?

In order to get to a program, people have to know about it. Obviously, little, if any, knowledge is evenly distributed in the society, and knowledge about particular services is no exception. Ignorance of a program's existence frequently prevents the majority of the poor from participating in it. Max Wolff and Annie Stein's study of Project Head Start in New York City, for example, showed that in contrast to the notion that people refuse to use services, nearly 60 percent of the parents interviewed who didn't send their children to Head Start had never heard of the program or had heard of it too late to register their children. Nearly 90 percent of those who heard about it too late said they would have sent their children if they had been notified about it in time.

The means by which programs are publicized naturally affect who learns about them. If the publicity about a program is related primarily through newspapers, posters and other printed media, it is less likely to reach the poorest. The Wolff study found that the Puerto Rican mother, living alone with her children and supported by welfare, was very much more isolated than the black mother in the same situation. Because little Head Start publicity reached these isolated homes, a substantially smaller percentage of Puerto Rican than black children was enrolled in the programs. When both Head Start and non-Head Start parents were asked by the Wolff interviewers what, in their opinion, was "the best way to bring more children into Head Start next summer?" the majority suggested home-visiting by local people explaining the program.

Furthermore, since much knowledge is spread by word of mouth, many programs do a lot of recruiting through the contacts of their existing clientele. Because most organizations do not deal initially with the poorest, those who are best informed about new programs are, in turn, likely to be the less poor. Last minute rush programs are unlikely to have careful recruiting methods. In a study of educational aides employed in New York City summer schools, one of us (Pamela Roby) found, for example, that administrative personnel had too little time at the start of the program to develop an active recruitment program to alert poor or nonpoor to the jobs. Consequently, those who learned about these job openings primarily intended for the poor were not the poor but largely students, relatives and other persons who were in communication with principals, coordinators, teachers, neighborhood antipoverty agencies and others involved in the summer school program. The old saw "It's not what you know, but who you know, that counts" has to be revised to include the fact that what you know often depends on who you know. In this case "who one knew" became important not because of deliberate nepotism and favoritism but because one needed to know persons involved in the program in order to know of its existence and job openings. The majority of the few unskilled low-income people who were hired as educational aides learned about the positions through schools or recreational agencies where they had been employed formerly.

In later years the real poor caught up with one program and filled most jobs. In Washington, D.C. and Pittsburgh, Daniel Yankelovich found that the majority of the nonprofessionals in community action programs were hard core poor. And this was so because of the fact that in these cities deliberate efforts were made to alert the poor to the new jobs. In Washington program workers went out on the streets, into the bars and even to prisons to stimulate applications. In Pittsburgh community meetings were held for recruitment purposes.

The second major question in the presentation of a program is the impression it gives to the people who do come in contact with it. Is it attractive? What does the service appear like to the poor?

The way the organization presents itself (consciously or unconsciously) very much affects whether people judge it as interested in their problems and capable of helping them. The social distance between agencies and those who might use their services is probably greatest for those at the very bottom. As a consequence, many of the poor avoid using services or present themselves timidly and withdraw quickly when forced by various emergencies to seek help. Two studies of Boston -- William F.

Whyte's in 1940 and Herbert Gans' in 1958 — describe the low appeal, and consequent low use, of middle-class-administered social agencies in low-income Italian neighborhoods. Gans noted that middle-class, unlike working-class "West Enders" viewed the agencies and institutions of the established society as supporting its aims, not theirs. The West End's middle-class "caretakers" never attempted to understand the working-class West Enders' culture, a close, peer-oriented society different from their own. Consequently, agency workers had to believe that "the West Enders' refusal to follow object-oriented middle-class ways was pathological...." The West Enders, in turn, viewed the "caretakers" as deviants. It was hard for the twain to meet.

More recently it has been again realized that "means tests," intended to provide services specifically for the poor, tend to become stigmatizing and humiliating experiences for low-income clients. Consequently, many individuals do not use services they need and are entitled to. Various experiments have been begun in an effort to eliminate degrading means-test ceremonials. New York City appears to have reduced the amount of demeaning questioning and probing but a certain amount still persists. Joseph Goldman reports that even in the experimental centers, "the use of caseworkers as intake staff appears to foster a situation in which there is an undue concern with past patterns of behavior and an excessive exploration of background issues during the determination of eligibility. Many workers have been unable to accept the client's own declaration of eligibility as the sole basis for deciding eligibility. They feel that it is their responsibility to 'catch' applicants who may not be truly eligible." Recommendations have been made to change this situation.

Finally, people may also be barred from a program prior to admission by its physical inaccessibility or its inconvenient hours of operation. Physical inaccessibility is not merely a matter of where the service is located but of the relative ease with which the poorest people can get to it. Frequently, services are far from the poor, and even when efforts are made to bring services closer to the poor through decentralization, agencies tend not to be located in the poorest neighborhoods. Location affects who sees and consequently who learns about a service. And because transportation is less available to the poor and the poorest, the physical location of services also crucially affects the apparent availability of services and who will stay in and complete a program. For example, Max Wolff found that 6 percent of the parents whose children did not attend Head Start kept their children at home either because the mother was working and had no one to bring the child to school or because there were young babies at home whom the mother could not leave. Similarly, 1,082 of the 58,700 trainees who left the Work Experience and Training Program Funded under Title V of the Economic Opportunity Act between the fall of 1964 and the spring of 1967 indicated that they did so because of transportation problems.

Thus in the presentation stage, even prior to the determination of admission, an individual may be excluded from a program by his ignorance about its existence, by being turned off by the impression it gives him or by finding it physically inaccessible.

Admission

Those individuals who surmount their first hurdle face admission. What happens to people who apply for a service or a program? How do agencies treat them?

Very often applicants for services are not simply admitted or rejected. They are made to wait for long periods in noisy, overcrowded and bleakly uninviting places with inadequate seating. The use of waiting lists to keep people in nominal touch with a program but not to provide services tends to push out or drop out the poorest. They have the least resources, and when they apply for services they usually need them immediately. The waiting list has the effect, often unplanned, of getting rid of such people. In some cases the immediate emergency passes before the red tape of agencies is surmounted. Somehow a family manages to get through days without food money or months without furniture.

Anselm Strauss has noted (*trans*-action, May 1967) that in the field of health, the system of frequent referral to specialized clinics results in fragmented care and often total lack of care. In a survey, George James found an elderly indigent man who lived near one of the largest medical centers in the world whose life illustrated the problems presented by many referral systems. The man, who had been labeled as an "uncooperative" patient by the hospital because he had stopped attending the clinics, had 12 major pathologic diagnoses. He had been told to attend no less than ten specialty clinics; but as he was too sick to do this he stopped attending any.

Admission does not mean that the waiting is over. Each visit for services may mean more of it. Mothers who cannot afford babysitters for their young children have to wait two or three hours in clinics for medical treatment for themselves or their children.

In admitting individuals into a program, agencies use a variety of standards. These criteria lead to the exclusion of the poorest from the potential benefits of the program. Agencies want to know if the applicant is a good risk and if he is easy to manage. Formal qualifications such as education, age, permanent United States residency and a clear criminal record also bar many from programs.

In May 1968 New York City liberalized its standards for admission to low-income housing. The old standards, similar to those still existing in many cities, illustrate the bewildering complexity that may characterize the admissions process. Under the old system, a family whose members fell into any of 21 behavior categories was considered a "potential problem" whose application warranted further study by the authority's social service division. The consequent evaluation process took so long that chances of getting an apartment were remote if an applying family were referred to the social service division. The old behavior categories included out-of-wedlock children, alcoholism, narcotics use, "a record of antisocial behavior," membership in a "violent teen-age gang," a history of poor rent payments, frequent separations of husband and wife, a common-law relationship, mental illness that required hospitalization, "unusually frequent" residence changes, poor housekeeping standards "including lack of furniture," "obnoxious conduct" in applying for public housing and whatever other traits might indicate future trouble. The following six criteria are still included under the new procedure: a history of recent serious criminal activity, a pattern of violent behavior, confirmed drug addiction, conviction for rape or sexual deviation, grossly insanitary or hazardous housekeeping and a record of serious disturbance of neighbors, destruction of property or other disruptive or dangerous behavior.

In some programs, periods of testing to determine the appropriateness of the individual for the available service and of waiting for test results may be a trying experience leading applicants to drop out before they are either admitted or rejected. There may also be a process of routing individuals through a referral system to other places. The net effect frequently is that the poorest do not get the service, either because the receiving agency does not provide it or because the client eventually gives up.

Thus it is frequently difficult to separate withdrawal by the applicant from exclusion by the agency. The style of decision-making and decision-makers may inadvertently or deliberately induce withdrawal. The overall result, we believe, is that services have been kept away from the poorest.

Completion

Who completes a program, and what is involved in their completing it? There is a big difference between those who begin and those who finish a program. The percentage of beginners who go on to "graduation" is frequently low. For example, during the program's first nine months in existence, 2,800 enrollees dropped out of the Department of Labor's Concentrated Employment Program without completing the course. Forty-six percent of the enrollees in the Department of Health, Education and Welfare's Work Experience and Training Program were dropped from or dropped out of the course before completion. The reasons given for the 25,858 enrollees leaving the program were, in the order of their frequency (and excluding the problem of accessibility noted above), poor attendance (which may be caused by many organizational and individual factors), lack of child care, dissatisfaction with assignment, termination of projects, lack of progress, misconduct, refusal of assignment and inconvenient hours of work.

Completion of a program is conditioned by the effort a person must expend to remain in a program, the willingness of the agency to keep him, the continuation of the program itself and the amount of benefit he believes he is receiving or will receive from the program training. Agencies can make it easier for individuals to remain in their programs by providing transportation and child care services and, as in the case of manpower training programs, by paying the trainee a small stipend to compensate for the income he may forego during the training and to allow him to maintain himself. Agencies vary in their understanding of and openness to various modes of individual behavior. In some agencies, people whose behavior does not conform closely to middle-class styles are encouraged to leave or are dismissed prior to completion. All too frequently completion of a program is entirely outside the clients' control because the entire program is terminated by the lack of renewed funding.

The amount of benefit a client believes he is receiving or will receive from a program depends upon both its mode of presentation and the actual benefits it confers on him and on others who have progressed further through the program. Individuals are more likely to continue with health or training programs, for example, if the reason for particular treatments or training is made understandable to them.

The completion stage of some programs offers the benefits the client seeks immediately, while others are geared to preparing the client to seek the benefits after he finishes the program. For example, the "new careers" programs allow nonprofessionals to work in stimulating jobs as they learn, while other programs require the individual to complete weeks of training without the guarantee of a job at the end. People are likely to drop out of the latter programs if they see that friends and neighbors who finish before them are unable to obtain jobs or other promised benefits -- the final stage in the delivery of service.

Aftermath

In evaluating social services it is not enough to ask merely about the availability of services and the numbers who complete various programs. We must also ask about the aftermath of services. Does anyone benefit from the services? If so, who? How lasting is their benefit? Does the improvement in the individual's life help him obtain other benefits for himself or others?

The unfortunate fact that completion of manpower training programs does not guarantee jobs is illustrated by the Department of Labor's Concentrated Employment Program. In the early stages almost half of those who had completed one or more training programs were waiting for jobs or transfer to another program. Of the 56,000 trainees who completed the Work Experience and Training Program, 28 percent had not been immediately employed.

The JOBS program, which subsidizes private employees who hire so-called hard-core workers, has recently been damaged by other government policies. The deliberate contraction of the economy by the Nixon Administration has led to the firing of JOBS workers, notably by the Chrysler Corporation. The most-difficult-to-place workers are those most likely to be adversely affected by economic recession.

At the same time, however, a person may benefit from a program without completing it. For example, the Neighborhood Youth Corps frequently functions as an aging vat by allowing youth to maintain themselves until they grow up into the more employable "non-teen-age" status.

The Westinghouse study of Head Start concluded that brief summer programs were ineffective in producing any gains in cognitive and affective development that persist into the elementary grades, but that full-year programs, while ineffective in regard to the measures of affective development used in the study, were somewhat effective in producing gains in cognitive development that could be detected in grades one, two and three. The Westinghouse report also noted that all-black Head Start centers in the Southeastern United States and scattered programs in the central cities appeared to be more effective. It would be useful to learn what differentiated these more "successful" programs from the others. The Westinghouse researchers themselves stress that their study sought only to determine the degree to which Head Start had a psychological and intellectual impact on children that persisted into the primary grades. The study did not address the question of Head Start's medical or nutritional impact; it did not measure the program's effect on the stability of family life; nor did it assess Head Start's impact on the total community, on the schools, on the morale and attitudes of the children while they were in the program.

For and against creaming

In the delivery of services the poorest are the most likely to be excluded or left behind at each of the four hurdles discussed above. It is unlikely that these exclusion processes will be eliminated from either selective poverty programs or universalistic programs aimed at benefiting all segments of the population, for they serve several purposes of agencies and their staff. Exclusion homogenizes institutions and programs. Their staff can more easily manage the agencies. Exclusion of persons less socialized to middle-class styles and current agency practice allows older institutions to avoid large-scale change; those most amenable to existing programs are chosen or asked to participate. Real success comes slowly to the poorest, for they have the farthest to climb. By including only the already upwardly mobile poor, a program is more likely to have "success." It can then impress Congress and foundations with its achievements and gain more funding.

Thus many agencies have conflicting objectives. Their efforts to reduce risk, to make a record and to help those most likely to benefit from assistance all work against the objective of dealing with the poorest.

Creaming can also serve to maintain the status quo of the larger society. It co-opts the potential or actual leaders of the poor and leaves untouched those poor who may be too miserable to pressure for change.

Exclusion enhances the prestige of those who are included. For this reason, many universities on the way up make great efforts to keep out poor students, frequently without filling their enrollments, so as to enhance the prestige of the students whom they do enroll. Similarly, manpower training certificates may be more respected by potential employers if a relatively select few of those needing training are allowed to participate in the programs.

Creaming may be beneficial in certain circumstances, but in others, perhaps most it is harmful. When creaming occurs, those left behind become disillusioned and embittered. They see that not only have promises been left unfulfilled once again, but they are in a worse position than before the programs began. Now they are asked, "Why didn't you take advantage of these programs?" They are labeled with yet another failure. When programs move the least poor out of ghettos, the poorest are left in neighborhoods shorn of their old leaders and of whatever assistance the less poor could give.

Creaming may lead the larger society to believe mistakenly that easy success is possible and that limited resources can have a great impact on the poor: "a little can do a lot." The consequence may be to reduce pressure for spending on the scale necessary for real change in the material conditions of the poorest. In addition, creaming may result in confidence in methods and approaches for solving the problems of all of the poor that are useful only for a restricted band of already upwardly mobile poor.

The benefits of programs provided for the less poor of the poor do not filter down to the poorest because the former frequently leave their poor communities as a result of the help they receive. Also, methods that work with the less poor frequently do not work with the poorest. On the other hand, services for the poorest frequently benefit the whole of the poor community. They do so first because when the poorest are better able to cope with their own problems, they are less likely to be disruptive and more likely to be contributing members of the low-income community. Second, when services are initiated first for the poorest, they are likely to be sufficiently flexible to be later adapted to the less poor; the reverse is frequently not true. Third, when services are initiated first with the poorest, the less poor who want to be included in the programs generally have the strength to politically organize and demand that they too receive such a service. For example, middle-income parents have demanded that their children also be included in Head Start programs which were initiated for low-income children. While the less poor and the middle income frequently have the political strength and know-how to demand that a greater portion of the nation's resources be devoted to social and educational services so that they too may be included in programs originally aimed for the poorest, the poorest by virtue of their poverty do not have the strength to make such demands for themselves.

An answer from France

How can creaming be combated? Only a deliberate counter-policy can prevent the natural tendency of organizations serving the poor to serve the better-off of the poor. Agencies must be make aware of whom they are including and excluding at each step in the delivery of their services. Inclusion of the poorest will not occur naturally; the poorest must be actively recruited and helped to complete and benefit from services.

Employment of the poor and the recently poor on social service staffs may make the services less ominous to the poorest. Training programs can help make social service workers from non-poor backgrounds more aware of creaming processes. Peter Blau has demonstrated that the general orientation of the organization and its leaders is also important. If an organization is positively oriented toward working with the poorest, the actions of individual workers are likely to reflect this orientation whether or not they personally believe in it.

Funding agencies and the general public must be taught to recognize creaming in programs and be made aware that creaming harms the poorest. Foundations and government funding agencies can help combat creaming by requiring agencies to report on the economic, educational and other characteristics of people who apply to, complete and benefit from their programs. They can stipulate that the poorest be included in programs and emphasize their needs. Outside agencies and individuals can also deliberately check on whether organizations are creaming and criticize those which do.

A useful model is that of the French poverty association Aide à Toute Détresse (ATD), whose primary objective is anti-creaming or working with the poorest of the poor. The association checks on government programs and acts as an advocate of the poorest when programs or services intended for all are found to exclude them. ATD found, for example, that the poor in many of France's shantytowns were not included in the nation's censuses or its educational system. The fact that education and many of the nation's welfare programs were not universal went unnoticed. At the insistence of the Association, the nation has now provided buses to take young children from the shantytowns to distant schools. The Association also drew on its experience with the children in the shantytowns to help teachers and schools develop means of working with these "new" youngsters. Within the shantytowns ATD workers helped parents and children learn how to cope with and benefit from the educational system. A team of Aide à Toute Détresse volunteers who have been living in New York's Lower-East Side for the last several years have found similarly that the poorest, most "difficult," children of the area are continuously sent home or totally excluded from schools, social services and tutoring programs.

The Association's volunteers are keenly conscious of the needs of the poorest because they live as well as work within the poor communities which means that they share, around the clock, the conditions of the poor and learn, first hand, the effects of various community conditions and of social services intended to help the community. By living in the community they eventually also become trusted as neighbors. The poorest as well as the less poor of the community come to seek the help of their ATD neighbors...sometimes to use their telephone for an emergency call; sometimes to inquire about where to go for legal services; sometimes to figure out what to do when a son has continuously been kicked out of school. Because the volunteers are neighbors, they are accessible day or night, they present familiar rather than forbidding faces, and they frequently do not have to be filled in on all the details of a problematic situation.

We have made two assumptions which should be made explicit. One assumption is that the services and resources which are being distributed are worth getting. We are not fundamentally questioning the usefulness of these services as are some critics and social scientists. Our analysis centers only on the distributive question of who receives the service or resource. If the question of relevance or usefulness is introduced, then new issues emerge. Does the availability of one kind of resource or another differentially benefit a particular section of the poor? It might be, for example, that an emphasis on providing services rather than money usually results in the better-off of the poor receiving a disproportionate amount of the service, while a program providing cash aid on the basis of need is more likely to benefit those at the bottom.

The second assumption is that it is desirable to concentrate more resources and activities on the poorest than is now done. In contrast, it can be argued that as long as social welfare funds are limited, creaming is useful and desirable social policy. Persons holding this view maintain that society should concentrate resources and programs on those more likely to benefit from them and that as the least poor graduate from poverty the resources may be transferred to the group just below who presumably have the best chance of benefiting from the resources. A cost-benefit analysis might well come to this conclusion, for, as Leonard Granick has pointed out, social services do not at the moment have enough manpower or resources to assist successfully both the "easy shots" and the "hard shots." Indeed, we may also lack the technology or knowledge necessary to assist successfully the hard shots. Inadequate resources and knowledge, or course, say more about society and science than about the poorest.

To argue for the importance of recognizing creaming tendencies and for the desirability of combating them is not to assert that anticreaming is always the first priority of poverty policy. But it should have a high priority position. We will only assert here that creaming cannot always be the most useful policy. There are losses as well as advantages in it, and creaming is often the unplanned consequence of purposive social actions to aid the poor. We need a better balance between unplanned and widespread creaming and planned concentration on the worst off.

Concepts of Community: Is It a Where, a When or a How?

Anthony F. Panzetta

Certain words have a way of taking on meanings never intended. Words of a high level of abstraction are like that. Because they touch so many diverse phenomena, these abstract terms are both practical and impractical at the same time. "Community" is an example of such a word. It can be applied in a variety of situations and so is versatile as a oneword concept. But it also is prone to multiple connotative meanings and so can be easily misunderstood.[1]

In today's mental health vocabulary, "community" has taken a prominent position. To some it rings a public health note, to others it has a socio-political connotation. It may suggest a neighborhood, a district, or an ethnic grouping. It may generate a mood of warmth and togetherness or one of pragmatic association. It has a current mystique, however, which transcends any of the usual denotative or connotative meanings. This is a mystique of value, an inherent sense of goodness attached to the various concepts of community. To be pro-community is to be virtuous; to be anti-community is to be evil. Both assessments precede any attempt to clarify what is meant by "community."

Since "community" is so vital a concept in a movement which presumes to use the term to describe itself, it is necessary for us to start with its critical analysis. We shall consider it first from a sociologic perspective and then as a geographic concept, a temporal concept and as a functional concept. The implications of the popular movement of "community control" will be considered as will the racial issues which confuse the concept of community.

Gemeinschaft and Gesellschaft

Sociologists have grappled with the concept of community since Comte and philosophers since Plato. It is unlikely that we shall settle on the ultimate choice here. There is a useful distinction for our purposes, however, that was elaborated by Tonnies in his use of the terms "gemeinschaft" and "gesellschaft."[2] A gemeinschaft community is characterized by an implicit bond which relates person to person. Like the extended family, such a community is held together by common values, affection, mutual dependence, respect, and a sense of status hierarchy. There are no formal rules of relationship and the roles of the members of that community are set by the traditions and cultural expectations of the group. This type of community is becoming increasingly rare and depends for its existence on a rural or feudal type of social organization.

Today's dominant type of community is "gesellschaft" in nature.[3] This is a developmental fact due in great measure to the growing urbanization of modern society. Here the bonds are formal and explicit. People relate to one another through formulated guidelines or even rules and regulations. Affection and dependence on one another for survival is rarely operative. In the gesellschaft community people come together through formal institutions, like their place of employment, their church or their professional or civic organization. Often great blocks of time are spent in these vertical groupings (in institutions usually away from the area of their home) in contrast to the lesser blocks of time spent in horizontal groupings (in their home neighborhood).

It is the reality of the gesellschaft and the longing for the gemeinschaft which often lead to a misorientation of "community minded" psychiatrists. While it is true that there are territorial commitments which all persons make to their "home," and while it is true that this commitment is apt to carry with it affective and durable qualities,[4] it is anachronistic to program for a form of social organization that no longer exists (gemeinschaft). It would seem much more reasonable to program for the dominant form i.e., the gesellschaft. If there are existent gemeinschaft forms in the population, then these can be taken into account, but not to the exclusion of the more prevalent gesellschaft forms.

The visible manifestation of the gemeinschaft approach to community mental health planning is the "catchment area." Here a geographic area is designated as target area and all those who live within the specific boundaries are members of the mythical gemeinschaft. This horizontal approach to community makes sense from a limited public health point of view because it allows for the assignment of responsibility. But this goal, i.e. the fixing of responsibility, is an operational accomplishment and does not speak to the issue of community.

There is a further paradox implicit in this approach. One of the ways a gemeinschaft group is maintained is by a radical

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provincialism. Remnants of such groups remain in some of the ethnic communities of Chicago and they have been able to maintain this Old World coherence by inbreeding and careful exclusion of cultural values of the pluralistic community around them.[5] They have resisted acculturation to an extent (although the resistance is disappearing rapidly) and so are set apart. The Amish settlements of Pennsylvania and Indiana are better examples of the gemeinschaft community. But again, in all of these examples, the gemeinschaft is preserved by a non-integrative approach to the larger surround. The paradox rests with the black neighborhoods which to some extent have also maintained a gemeinschaft way of life but by enforced exclusion from the larger community. Since many, if not most, of the community mental health centers are in black areas, they are forced to program their services in such a way so as to reinforce the separatist ethos of that area. Although this approach may fit into the plans of the militant black activist, it should be recognized as what it is, a closed market.

A visible remaining example of gemeinschaft living which persists throughout modern society (although under great pressure) is the family. It makes great sense to program for family oriented services since this social form is naturally occurring and durable. But it is possible to program for family oriented services without paying a great deal of attention to the horizontal community orientation.

This perspective, which differentiates the vertical (institutional) community from the horizontal (geographic) community and which separates the gesellschaft (formal) relationship from the gemeinschaft (mutual dependent) relationship, can and should clarify some of the inherent difficulties as mental health centers program for their assigned "community" (catchment area).

The resolution of this seeming dilemma lies in the careful application of logical definition. If the overriding consideration is the need for a system which fixes medical and paramedical responsibility, then the catchment area concept may indeed be optimum. But to go further and equate catchment area with "community" is a non-sequitur. If the primary goal is to develop programs which fit the idiosyncrasies of a discrete community, then the catchment area concept is meaningless unless the boundaries of the catchment area coincide with the boundaries of an existing gemeinschaft community. If such a community is identified, then we must realize that our efforts may very well serve to reinforce the separatist and exclusionary character of the gemeinschaft community.

Where: Community as catchment area

In a clear way, the catchment area community is a "where" community. Its definition is dependent on street names, buildings and general demography. It can be isolated on a wall map which then becomes an impressive addition to one's office, particularly if there is a war games disposition. Colored pins can point out the structural parts of this community and a sense of "my turf" is quickly established. The basic orienting grid to one's thinking becomes "those people living between Susquehanna and Diamond Streets." The great temptation is to assume that "those people" are like one another in their sense of community, i.e. they share common beliefs, common problems and common aspirations. What in fact is the reality?

There is a commonality which presents itself in the "where" community if that community is sufficiently oppressed. The social indicators of such a community are familiar in language today, i.e. high death rates, high infant mortality, dilapidated housing, high crime rates, etc. And so the common factors extracted from such a community become logical targets for intervention. These are the "symptoms" of the "where" community and hence the illusory logical target for the community psychiatrist. But the roots of these "symptoms" are not "where" in their vulnerability. A geographic approach may give topographic clues to what is between these boundaries, but it also fixes you to the out-field when the real action is in the in-field. The dilapidated house on Diamond Street is a complex phenomenon derived from City Hall, the money market, the suburban ethos as well as from events and people within the catchment area. If we choose to define our mental health goals in this grand dimension, we had better not assume a catchment area orientation in our programming.

The analysis of a "where" community is usually written in the language of demography and epidemiology.[6] This defined approach gives valuable information about the target population but it is important to realize the type of information that is supplied. The information on incidence and prevalence for example is only as good as those criteria used for the identification of a "case." The more abstract these criteria, the more unreliable are the results. Because of the availability of rather discrete criteria for the identification of schizophrenia, it has become a favorite object of epidemiologic study,[7] and the results of such studies have a higher degree of validity than studies of more diffusely defined conditions, such as the Mid-Town Manhattan Study.[8]

The point of all this should be clarified here. If a community is defined in "where" terms, its analysis, i.e. the dissection of its "problems," is biased in the direction of measurable and gross phenomena. What emerges is a picture of the social disorder of that area as reflected in incidence and prevalence rates of the high visibility problems. Programming for the "where" community will therefore inevitably tend towards these high visibility problems. This may or may not correspond with planning objectives derived from other considerations. It is reasonable to proceed from this point of view providing one realizes what is happening. And again, what happens is that the high visibility problems surface and become the crying targets for a "where" oriented community program.

In my experience in a mental health center with a catchment area, "where" approach, the above proved accurate. Although our group initially programmed for general psychiatric disorders, we felt the pull towards the high visibility problems of juvenile crime, unemployment, alcoholism, and addiction, geriatrics and mental retardation, soon after we were operational. It led some to wish we had planned originally for these high visibility problems and it led others to frustration since few of these visibility problems are "attractive" or "responsive" to the psychiatric and para-psychiatric professions. So despite an earlier general orientation, the consequence of a "where" approach may shift the focus of attention elsewhere.

A collateral effect of this horizontal concept of community is to place a pseudo-sociologic aura to one's efforts. This may be an exciting prospect initially as one becomes imbued with the sense of innovation and the illusion of being an instrument of social change. However, illusion it is, because entrance to the social institutions which create and devour the social condition requires skills, power, and time beyond the resources of the mental health center as a collective force or the psychiatrist as a well-meaning individual. The problem is that an aura does exist and it takes time before this aura is recognized for what it is. During the interim, staff and program may easily be pulled down the road to its inevitable disillusioning dead-end.

When: Community as epiphenomenon

One of the alternate ways to consider the concept of community is to place it into a dimension of time. We have all been aware, at one time or another, of a sense of community which comes and then goes. People commonly band together to accomplish certain discrete goals and then disband. Organizations often prove to be "when" communities as they bring people together in common pursuit over a period of time. If we wished to look back, with a reverent historical purview, to the feudal gemeinschaft communities, we would still note the dissolution of that communal form over time.

Time, of course, changes all things or more correctly, all things change in time. The great leveler of human grandiosity, history, has been able to chronicle, with predictable certainty, the demise of all sorts of social organizations.[9] Civilizations and families alike are modified or terminated. But too great a preoccupation with the dimension of time becomes distressing and discouraging. After all, we must acknowledge our own temporal finiteness and the even greater temporal finiteness of our work. To feel that one's work must endure forever or to fear that one's work will be washed away immediately is to be equally absurd at either pole.

The hard core reality of the temporal dilemma is that it is very difficult to correctly estimate (a) if the phenomenon we are observing is an artifact of the time or a durable reality and (b) if our response to the phenomenon is appropriate to its duration. Is it a short range solution to a long range problem or conversely a long range solution to a short range problem? The dilemma is more often than not worked out in retrospect.

When time is applied to concepts of community, it brings to them an element of uncertainty which should humble the community expert. Most so-called communities are so time bound that they come and go like evanescent clouds. The conditions which create a community are themselves so fragile that community itself is more correctly an epiphenomenon than a primary reality in its own right. This concept of community as epiphenomenon is exceedingly important for anyone who is working in "community oriented" work. An epiphenomenon is a phenomenon which occurs as a result of pre-existing phenomena or set of conditions. An epiphenomenon is nothing unless the pre-existing events occur. And likewise a community, in its "when" sense, does not exist unless certain conditions exist.[10]

These necessary conditions would seem quite important to recognize, yet it is extraordinary to witness the degree to which they are ignored by "community oriented" workers. There is probably no greater cohesive force by which people come together into epiphenomenon community, than that of oppression. The history of the Jews and now the Black experience in this country are graphic documentation of this fact. To take away the oppression is to take away much of the binding power of the community. To take away the oppression is to dissolve the epiphenomenon.

Working classes after the Industrial Revolution learned the lesson well and the organized labor movement in this country was the epiphenomenon of that capitalistic oppression. Even today, unions are maintained as organizations only as well as management is able to play the role of potential oppression or to be placed in that role by union leaders.

Oppression is only one of two necessary conditions for the epiphenomenal community. The second is leadership. That sense of shared values, common goals and kinship which is community must be articulated and transmitted to those persons who are to comprise the community. An oppressed people remain fragmented and isolated as long as no one stands to call them together, point out their common plight, articulate their frustration and present a plan for joint effort. Community implies unity and unity implies the condensation of many voices to one or few. Given the two necessary conditions, oppression and leadership, a community is born; take either of them away and the epiphenomenon vanishes.

A predictable objection arises here. Is it not so that there are examples of communities which persist without these two preconditions? Is not the family such a community? Again we must return to the distinction made earlier between gemeinschaft and gesellschaft communities. The gemeinschaft community exists only in rare instances outside family life. The traditions and way of life which nourished and sustained the gemeinschaft community are gone. And so we see as the prevalent form the gesellschaft community. It is my contention that there are episodic variations in the usual gesellschaft model which tend to take on the characteristics of the gemeinschaft community and that these variations occur as a result of two major conditions coming together. The resulting "sense" of community lasts only as long as these conditions and so the "gemeinschaft" community is not a durable gemeinschaft at all but rather a fragile state which we can term an epiphenomenon.

There are several implications of this perspective for community psychiatry. Those community mental health programs which have developed in suburban or affluent areas are characteristically oriented towards the provision of services to individuals or families. Their community orientation is primarily geographic and a function of fixing responsibility for various services. They have inadvertently but accurately perceived the lack of gemeinschaft. On the other hand those community mental health programs that have developed in urban centers, with a predominantly Black and oppressed constituency, have noted a sense of community and have tried in myriad ways to relate to that sense of community. It is here that the confusion is generated.

If a mental health center assumes that the community is bound together in an historical and romantic way and makes overtures for joint responsibilities, it will soon enough discover that the community will act and respond "as community" only in those issues directly related to oppression or related to the roles and prerogatives of their leaders. It will not receive a sustained community input on those more pedestrian issues that have to do with the delivery of psychiatric services. If the psychiatric services can somehow be brought into the oppression equation, then interest may exist but it will be short-lived. Again I must clarify this statement. Community interest -- that is, the *representative* sentiment of a large group of persons, expressed by responsible leadership -- can be sustained only in those areas directly related to their binding power as a community, i.e. the binding power of oppression and leadership. The interest in a mental health program can be generated in isolated "community" individuals who for one reason or another are interested in mental health matters, but do *not* assume that these interested individuals can represent a community in matters other than those related to their oppression. Even in the latter area representative views are difficult to identify.

The confusion is brought into stark relief when the community mental health center seeks to "find" its community. "Who speaks for the community?" is the plaintive cry. The answer of course is that there is no community out there, as there is no community out in the suburbs unless you are interested in getting to the epiphenomenal community, which is there for reasons already noted. In that case, the response is a relatively predictable one -- and it is inexorably linked to issues of great social import. That community voice will speak to the mental health center about oppression and demand that the center take a role in their struggle. Many centers have and will attempt to get into that struggle. They are then epiphenomenal centers which will ultimately depend for their existence on the maintenance of an oppressed community.

If a center "turns its back to the community" and selects out those residents of the area interested in the center's conception of mental health services, it then runs the high risk of being identified as not truly a "community" mental health center.

How: Community as Instrument

If the foregoing concept of epiphenomenal community is plausible, then what remains to be discussed is the functional role of that tentative community. If there are urban communities marked by oppression and secondary communal "togetherness" then *how* do they operate in their common goals? What is the basis of their instrumental effectiveness? Although there are many ways to address these questions, I shall select the following approach because it captures the reality of today's urban life.

The ultimate instrumental force with which a "community" may attempt to impose its collective will is that of confrontation. After all, there would be no "community" had there not first been a condition of oppression and hence a state of imminent conflict. The very creative force responsible for the emergence of community is itself a real or imagined threat and so the counter force is its putative equal, counterthreat.

The point of this is to identify the fundamental force which, on the one hand serves as the community's power and, on the other, as a reinforcement of its sense of being an oppressed victim and hence a reinforcement of its sense of community. This force of confrontation must be analyzed into its various forms and a would-be provider of "community mental health services" must accurately perceive its proper relation vis-avis these forms of confrontation.

A community has at least four levels of confrontation that it can mobilize: (1) as physical force; (2) as anti-participant; (3) as franchiser; (4) as consumer.

Physical force

This type of confrontation leaves little to the imagination and essentially is a call to violent opposition. It has become a common device in today's urban brinkmanship and is characterized by a burst from threat to action. It should be clear that the relationship of a mental health center to its "community" cannot be fashioned after this type of functional community role.[11]

Anti-participant

A community may view an institution as so contrary to its needs that it must take a vocal stand in opposition to its existence. One can imagine the mental health center whose real or imagined program is thought to be a further instrument of societal oppression. With that provocation a community could urge that no one participate as patient or employee or in support of the center. Again, this hostile relationship can hardly serve as a model for center-community interaction. It is a fact, however, that many centers are being described as instruments of social oppression and militant opposition has developed in many instances. But again, let us draw out the important distinction. Although there may be articulate and militant opponents to a program, it is a non-sequitur to ascribe this opposition to the ubiquitous "community." Truly anti-participant reaction from "the community," i.e. a broad level, grass-roots opposition, could develop only if a center could (a) capture the attention of the entire community, (b) behave in a blatently oppressive fashion so as to generate their cohesive opposition, and/or (c) through distorted charges of great magnitude, be incorrectly perceived as oppressor. These are extremely unlikely conditions and so also is a truly anti-participatory response from the community.

Franchiser

A community takes on a special relationship with a center if it is in the position of franchiser. This suggests ultimate sponsorship by the community, with consequent control (or "power" in today's vocabulary) of program, personnel and funds. On the face of it this would seem an ideal way for a community to "confront" an institution which attempts to provide it service.[12] However, the magic of the word covers the underlying absurdity. A community, in its true sense, does not organize itself in such a way so as to provide an authoritative control over an institution.[13] It will not yield a "representative" body with the abiding interest and competence to "control" so idiosyncratic an institution as a mental health center. To be sure, isolated individuals from here and there, for this reason or that, will rise "on behalf of the community" but there is little reason to expect in them the mandate or wisdom of the people for whom they wish to speak. It very quickly becomes an argument based on the visceral feeling...a little community is better than non at all isn't it?

Let us assume however that a community has developed its own internal system of representative voice and action. There are communities of this type. Here, I am not referring to the usual governmental structures which in their own way are "representative," but rather refer to area organizations (such as in the Woodlawn area of Chicago).[14] Such organizations have a way of maintaining their identity for functions far removed from their original intent. An organization formed to deal with housing or education could conceivably provide the sponsorship of a mental health center but to suppose that it is a "community" vehicle for control, support and responsibility may or may not follow. If the level of communication and mutual trust between the people of the community and the representative organization is consistent and durable, then it may well be an ideal franchiser of mental health services. It would be naive, however, to hope to create a new community organization concurrently with a new mental health center. Both require enormous amounts of dedication, sophistication and organizational skill. To have two mutually dependent institutions go through their separate and idiosyncratic processes together is to invite their mutual dissolution.

Consumer

The ultimate power of a community is that inherent in those persons who, by common need, accept or reject the role of service consumer. If the goal of an institution, like a mental health center, is to provide a service, then there can be no greater control than that which operates in the decision of a consumer to use or not use the service. To be able to extend this "power" to "the community" necessitates a relatively free market atmosphere. It means the provision of alternative services and the right of patients to choose that service which more closely meets *their* idiosyncratic need.[15] To close the options by creating catchment area boundaries is to imprison the people of that area and to insure their dependence on what could be an arbitrary mental health program whether by professional design or by design of those "professional" community representatives who speak with neither mandate nor clear vision.

The dilemma becomes clearer, however, when we fully appreciate the impasse. Given a catchment area exclusivity, we find a community voice impossible or improbable in each of the four functional strategies open to it. This leaves us with a peculiar conclusion: A community mental health center is neither of the community, by the community, nor for the community.

Given the reality of today's catchment area approach, with the consequent closed market for the consumer, the only viable functional role left for "the community" is as franchiser. As already noted, however, this will only be possible in rare instances. Again, at the risk of being redundant, let us restate that the concept of community in the foregoing refers to the evanescent gemeinschaft still to be found in the oppressed populations. It refers to their collective and therefore representative needs and demands and *not* to the interpreted needs and demands of a pseudo-community as articulated by self-appointed "representatives."

Community control: Grassroots and weeds

Community mental health centers face the same dilemma in relating to community as do all other service-oriented institutions. They are considerably more at risk because of connotations of terms like mental illness and mental health. Having been born into times of accelerated change they can hardly succeed in forging a self-identity. People are now "seeing" irrelevance in all or most institutions and so the wish or demand for institutional change runs rampant. "If they can't make their institution more relevant we will!" So goes the cry from the people...or at least some of the people. The "they" are usually thought of as alien, hostile and malevolent while the "we" are dedicated, altruistic and intrinsically instrumental. In today's heightened atmosphere of confrontation, the way to resolve a problem is to "confront" it.

The balance to the above is that many institutions are in fact unable to meet increased demands. The demands are now quantitatively and qualitatively more complex. The charge of irrelevance becomes an issue and a fact as long as the "demands" are not carefully defined and as long as priorities within institutions are not set. An institution that says to a community, "we shall attack mental illness" or "we shall promote mental health" is simply setting itself up for the rejoinder "you are irrelevant."

And so the issue of community influence, whether as the franchiser or as consumer is integrally linked to the issue of program goals. Someone has to decide what they shall be. A community will never succeed in imposing its goals on a center that is unwilling. And a center will never succeed in imposing its goals on a community if there are no consumers. The commonplace "battle for control" is an exercise in futility for both combatants.

A starting point is imperative. Let us start at the community end. If the foregoing has any merit we can anticipate two relevant community roles: (1) as franchiser and (2) as consumer. Either of these are possible but their possibility depends on the extant nature of the particular community in question. As I have indicated, a franchising community necessitates an existing "representative" body. The "incorporation" of interested community persons is an exercise in illusion. The incorporated body is as much a *special interest group* as any institution. Their special interest will emerge from their own narrow perspectives. To be willing to relate to such a franchising group is no different than relating to any institutional franchiser. To relate to a true community franchiser is desirable but difficult to attain.

What seems a rational premise is that the search for the "community" be abandoned. A search for the grail would be as rewarding. What then should a mental health center set about to do vis-a-vis its "community?" Contrary to the romantic readiness to do the community will, a mental health center must know, in advance, what it is it can do and wishes to do. Armed with this sense of identity and purpose it can turn to "its community" and identify itself. As part of its process of deciding what it is and what it can and wishes to do, it must also decide to what degree it wishes to balance its internal decision making processes by the inclusion of persons *identifiable* as (a) area residents; (b) vitally interested in the work of the center; (c) with the ability to conceptualize the types of problems and types of solutions involved; (d) with a willingness to *participate* and an ability to disagree as well as agree. This is "organizational sensitization," i.e. the conscious internal process of keeping an organization open to the life style and "needs" of its potential consumers. This is a process that should be initiated from within the Center. It cannot easily be imposed from without because that breeds organizational coercion and not sensitization. If a center's leadership does not choose to support and welcome the voices of its potential consumers then it simply will not have a sensitized organization. One may wish it to be otherwise but the difference between rhetoric and performance lies within those who must perform. This is nowhere more true than in the highly personalized and complex task of intervening in human behavior. As long as an organization can maintain an internal system of self-regulation so as to constantly focus and re-focus on its task, it will remain viable. This internal system of self-regulation will not work well unless it is truly internalized, i.e. unless there are multilevel consumer-oriented inputs.[16] The dependence on external inputs, such as with the common use of an advisory board structure, quickly degenerates into a pro forma relationship if there is no internal system of consumer influence.

Some centers have been able to maintain organizational sensitization by carefully seeing to it that area residents who meet the aforementioned criteria are hired for "meaningful" jobs within the center. The indigenous worker trend may be more important because of its influence as an agent of organizational sensitization than for its more explicit manpower resource role. If this is working well then good balance can come from an advisory board structure, providing the advisors and the internal staff have open communication with each other.

The point to all of this is to de-mythologize the term community and re-focus the issue around organizational sensitization. Simply stated this means the awareness of an organization of the multiple problems, some subtle and some not, related to doing its task. It implies neither a predetermined task nor one arrived at by representative election. Presumably there are some tasks for which persons in the mental health professions are particularly suited and some for which they are not. Once these tasks are made clear and decided on as organizational goals, then, and only then, should an organization turn to its potential consumer for help in maintaining its awareness to the problems in reaching its goals. If those goals are not the ultimate goals of a "community" (presuming those could be discovered), then it will simply become a service institution for a population group, with a priority (or "relevance") less than ultimate. It means being willing to see oneself as less than the savior institution and being willing to say to "community" voices that the mental health center is not the grand instrument of social renovation.

Issue of Black and White

This dilemma about community must be placed into perspective, especially with respect to its racial implications. The popularization of the concept of community is a corollary to the entire social awareness reaction of the last decade.[17] One of the fundamental catalysts of this social consciousness has been and continues to be the Negro struggle for equality. The tragic dimensions of this social revolution dwarf other processes involved in institutional renovation. Nearly every institution is caught up in its own attempt at renewal but the contagion and drama of the Negro plight have attached themselves to these various institutions. Their own future course now becomes enmeshed in the working out of the Black identity process.

It is conceivable that because community psychiatry has come into vogue in the wake of the Black revolution, its own identity and working through will be confounded by the vagaries of the more historically profound movement. There is a double-edged sword here. On the one hand, the moral impetus of the Black revolution has imbued the community psychiatry movement with an aura of moral righteousness and therefore its personnel has been enthusiastic and committed. On the other hand it has created a whole series of illusory goals, abstractly related to sacred concepts of mental health, and therefore it may have sealed its own ultimate frustration. Highly committed persons in an inevitably frustrating task...therein lies the potential tragic element.

The movements are distinct and separate. One, the Black revolution, is profound and touches the total fabric of our social structure. The other, the community psychiatry movement, is a moment in time, a transition stage between a narrow view of care to the mentally ill and a broader view with yet uncertain borders. Each has its own goals and processes. To begin to apply the jargon of mental health, developed to understand the individual, to institutions, communities and value systems, is to invite the collective wrath of those whose expectations will have been raised beyond our capacity.

There are so many red herrings with racial implications in the community psychiatry movement, that it is common to see the staff of a large urban mental health center devour itself as it seeks some new guilt reducing strategy. The amount of effort turned towards a therapeutic community approach becomes enormous. The irony however, is that the object of this therapeutic preoccupation is the center staff *itself* and not those persons for whom presumably the center exists. To ignore the reality of racial bias and its effects on the personnel of a center would be naive but preoccupation with organizational cleansing is a trap as self-limiting as any.

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5. In an old traveler's guide to Chicago (Drury, J.: *Chicago In 7 Days*, New York: Robert M. McBride & Co., 1930) the city is presented, in a series of maps as an amalgam of contiguous ethnic districts such as, Little Sicily, Italian section, Polish section, Greek district, Jewish district, Chinatown, etc.

6. Demography is the statistical study of human populations especially with reference to size and density, distribution, and vital statistics. Epidemiology is the science that deals with the incidence, prevalence, distribution and control of disease in a population.

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8. Srole, L., Langer, T.S., Michael, S.T., Opler, M.K., Rennie, T.A.: *Mental Health in the Metropolis*, New York: McGraw-Hill, 1962.

9. In their historical-philosophic volume, *The Lessons of History* (New York: Simon and Schuster, 1968) Will and Ariel Durant masterfully summarize the endless growth and decay of civilization as seen in the broad sweep of history.

10. Epiphenomenon, simply defined, is a secondary phenomenon accompanying another and caused by it. There is, for example, a theory of mind called epiphenomenalism which states that mental process are epiphenomena of brain processes.

11. The "take-over" approach, wherein "community" persons literally force institutional personnel out of offices etc., and then proceed to effectively close down the operation of the institution, is an example of the physical force approach. As a technique for a community to impose its collective will upon an institution, it is the most dramatic. When applied to a fragile institution, like a community mental health center, it promotes confusion and dismemberment.

12. Smith, M.B., Hobbs, N.: *The Community and the Community Mental Health Center*, Washington, D.C.: American Psychological Association, 1966.

13. The closest society has come to success in exerting truly collective will over its institutions is the republic form of government. Through the processes of nomination and election, the masses have delegated certain decision making rights to others. We are all aware of the enormous problems in this orientation, with political expediency, inevitable priority conflicts and parochialism. Self-appointed "representatives" constantly muddy the already murky waters.

14. Kellam, S.G., and Schiff, S.K., The Woodlawn Mental Health Center, *Soc. Sci. Rev.* 40:255, 1966.

15. Adam Smith's view of economic equilibrium leaned heavily on the belief that the need-demand vs. supply principle in an open market economy would ultimately work to the benefit of both the consumer and the supplier.

16. No consumer-oriented institution can survive unless it pays attention to its market. The market research department, within consumer-oriented industry, is a fundamental system which keeps organizational goals relevant to consumer needs. An analogic system within community mental health centers is critical.

17. In Durant (op. cit. 1968), one can appreciate the historical tendency for an alternation between concern for the individual and concern for society.

Community Organization in the Direct-Service Agency

Violet M. Sieder

The literature makes frequent reference to a distinction between agencies which use community organization as a primary method and those that use it as a secondary method. There is a tacit assumption that the "method" is a constant, and that the distinction lies more in the primacy or frequency of its use than in its nature. The explication of the method invariably draws upon experience from the organizations that use community organization as a primary method. Although every agency and every worker is exhorted to participate in bringing about social change, practically no attention has been given to the way in which an agency can best be organized to carry out this responsibility. Nor has there been critical examination of the community work roles appropriate to the administrator, supervisor, and worker.

A direct-service agency can be administered so as to make community organization process integral to its structure and staffing in relation to (1) facilitating the work of the central planning body; and (2) taking direct responsibility for effecting change in its own or other community services. A direct-service agency is one that works directly with individuals alone or in groups and employs diagnostic evaluation, treatment and other rehabilitative or service procedures. We exclude from consideration agencies that are designed primarily to serve people indirectly through facilitating or improving the work of other organizations: through developing an appropriate constellation of health and welfare services in the interest of a community's welfare; or through changing community attitudes. We recognize, however, that these functions are not mutually exclusive and that a direct-service agency's activities may indeed include and affect one or all of these other areas of service.

In achieving its goal every direct-service agency must perform three major functions: client work; community work; and administrative work. Each function has its own prerequisites, the satisfaction of which is dependent on the other two. These three functions operate in support of each other and in circular fashion.

Client work depends on prerequisites supplied through administrative and community work: recruitment of a clientele; staff adequate in numbers and qualifications; and such resources as funds, facilities, and other community-supporting services. Thus the community work function becomes integral to the operation of the agency. We stress this point because all too often boards and executives see work with the community as peripheral or extraneous to the agency's main task. They confuse service *to* clients with face-to-face work *with* clients.

"Community work" encompasses three distinct functions that engage the direct-service agency in active relationships with other organizations, outside groups, and individuals to facilitate the agency's ability to serve its clients. The three functions are: (1) interorganizational relations, including referrals, inter-organizational exchange and joint agency action on behalf of its clients; (2) mobilization of community supports for the agency, its program, financing, and ideology; and (3) change of community resources, including initiation, revision, elimination or combination of services needed on behalf of the agency's clients. To carry out these functions, the agency uses a variety of methods, including administration, research, and public relations and community organization.

An examination of the term "community work" will help to identify and distinguish between the several processes so frequently and erroneously lumped together under the rubric "community organization." In the course of recent research,[1] I have asked many social workers, nurses and rehabilitation counselors whether they engage in community organization. Though all these persons responded in the affirmative, they tended, in describing their activities, to include everything from a telephone call to a community resource, or a speech at the local Rotary Club, to a demonstration-research project or a social-action undertaking. If community work is to be furthered, it is important to analyze this legitimate agency activity in such a way as to identify the various unique types of functions involved and to specify the processes related to each. When we do so, we see that certain functions clearly do involve use of community organization methods, while others may apply only certain steps in the process, or may use entirely different methods.

This analysis will have value if it can serve as a tool in defining community work tasks and how they can be allocated to various staff roles, taking into account knowledge required. It also points to the importance of such administrative supports as staff training, reporting, recording, evaluation, and assignment of work load if community work is really to operate systematically as an integral part of agency function.

Direct-service agencies are inevitably and regularly engaged in interorganizational relations and in mobilization of

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community supports. The procedures for carrying out these functions, however, and the assignment of staff roles to them are far less formulated than for client work.

1. *Organizational interaction.* Specialization by fields and within fields of practice has resulted in a multiplicity of unique and autonomous agencies operated under both public and voluntary, both sectarian and nonsectarian auspices. This specialization makes necessary a network of well-defined and linked services, if each is to function effectively without gaps or duplication. We find this linkage both at the policy level, where functions are specified and sanctioned by mutual agreement (frequently through the offices of a planning council), and at the level of operations.

Bradley Buell's research[2] has amply demonstrated that people's problems are multiple and interrelated, and defy the neat categories of service reserved to themselves by agencies. To meet their clients' needs, agencies must have access to many types of specialized services.

Thus we see interorganizational exchange[3] being regularized through the formalization of referral procedures, negotiation of agreements on fees and service conditions, and reciprocal arrangements in the use of facilities and staff. At the policy level, agencies find it advantageous to work together on a treatment plan for clients, to clarify or make exception to policy, or to take joint action on problems of mutual concern.

If an agency is to engage in organizational exchange, its function must be specific and accepted by the agencies with which it interacts. Furthermore, it must make itself accessible to other agencies. This, in turn, calls for investment of staff time and allocation of authority to implement agreed-upon policies.

The staff must be equipped to carry these interorganizational assignments. In addition to knowledge of available resources — their function, scope, auspices, methods, personnel, and referral procedures — they need skill in the techniques of organizational interaction: conference and committee methods; consultation; negotiation; public relations; and social action. They also require sensitivity to intra-agency or program blocks, such as intake policy, which require agency reassessment and administrative or board action.

Interorganizational exchange brings into play top-level policy decisions and actions. Administrators must recognize the need to establish or modify relationships with key personnel in other agencies with which service elements are exchanged. These inter-related roles are each vested with responsibility calling for delegation of authority to act, and for accountability for these actions. A climate of cooperation imparted through staff attitudes and practices is as essential as formal interorganizational links in maximizing each agency's services.

2. *Mobilization of community support.* — Community understanding and support are requisite to the continued maintenance of a direct-service agency as part of a system of highly competitive and interacting health and welfare organizations. This support is vital to assure recruitment of clientele and use of the program; to win necessary financial support; and to promote the agency's ideology as part of an important movement or cause. These supports are even more essential when an agency attempts to expand its services.

An agency's ability to mobilize support depends on at least four conditions: (1) the existence of links with groups and organizations influential in the community's political, religious, and social life; (2) a comprehensive, focused two-way communications network which reaches the policy decision-makers, the contributors and clients — actual and potential — as well as the individuals and groups who mold public opinion (an important and sometimes overlooked function of this communications system is to breed community discontent over the conditions that are treated by the agency and thus to stimulate demand and support for its services); (3) an integrated social action policy to assure that lay and professional personnel are not working at cross purposes in such vital aspects of the agency's work as legislative action, budgeting, financing and public relations; and (4) a socialization process through which the community, or significant parts of it, will come to accept the necessity for, and values of, a program's goals and specific functions. It follows that the means used in introducing a new service element into the community health and welfare system is crucial to community acceptance as expressed through its use and support.

The methods employed to carry out the mobilization of support functions include: (1) organization of, and working with, lay boards, advisory committees, and volunteer groups; (2) assignment of staff and volunteers to represent the agency's interests and maintain relationships with civic organizations and citizen groups; (3) consultation with lay and professional organizations and groups on problems of concern to them to which the agency brings expertise; (4) mobilization of campaigns for legislation, appropriation, fund-raising, or other action programs; (5) public conferences and meetings which spotlight the agency's work; and (6) preparation and distribution of materials and reports.

3. *Change of community resources.* — It is frequently stated that direct-service agencies have a responsibility for

identifying unmet needs and for bringing about change in community resources. Ways of discharging this responsibility are, however, seldom identified or, at best, are vaguely described. The stake of the agency and of the direct-service worker in bringing about change in community resources is clearly related to three conditions that affect their ability to serve their clientele.

Inadequacies in the variety, quantity, quality, and availability of services. A community's network of interrelated health and welfare services is imperfect at best. Even in the rare instances when the community provides a full complement of essential services, their use is too often limited to persons who qualify by sex, geography, religion, or the nature of the presenting problem. Then again, a prospective client may be deprived of help because intake is closed, the quality of the service unacceptable, or the fee too high.

Progress in knowledge and methods. The increased tempo and depth of research undertakings in social welfare and related fields of social science have great significance for agency practice. New knowledge of treatment procedures or program designs may make it desirable to revamp existing services or to create new ones.

The changing nature of community. Shifts in a community's population characteristics, economy, political situation, and social values may create new problems which demand corresponding adjustments in social services. In short, community services must be conceived not as static "givens," but as flexible programs that can change to meet new conditions. The older definition of community organization as "a balance between needs and resources" must be altered to include the concept of community services as a moving equilibrium in which the place and weight of the parts must shift in relation to one another, as well as move forward together.

Assuming that the case has been made for change, what can an agency do about it? After all, the worker has to use the resources at hand. This frequently means improvising, circumventing formal agency policy, or persuading individuals or civic groups to meet the costs of client care in another community. Or it may mean "helping the client adjust to the realities of his environment." It certainly can mean frustration and loss of valuable time for the conscientious worker. Is it any wonder that sensitive workers may face the choice of becoming hard-boiled, leaving the job, or going crazy?

But what of the clients? They slip between the cracks of agency functions and are heard from thereafter in the courts, in penal or mental institutions, or through future generations of problem family progeny. How often have we listened to our colleagues bemoan the guilt they feel because someone was refused at intake, someone whom no other agency could help? It was not because service was not clearly indicated, not because an appropriate method or procedure was not known, but rather because the client's needs did not match the specialties offered by the existing agencies. There just was no place to which referral could be made.

Even though the staff worker will, on occasion, have to innovate to meet immediate client needs, he must be given a responsible role in bringing about change. This is as important to his professional growth and mental health as it is to the welfare of the clients he serves.

A widening gap is appearing between agency staff members, with their firsthand knowledge of the adequacy or inadequacy of services, and those persons who are vested with power and responsibility for improving community services. Public and voluntary agencies, their boards, and their staffs tend to be pushed more and more to the side lines of community-wide planning, in large part because they have been satisfied to function as instruments technically qualified only to offer their special brand of service. They, and the central planning bodies with which they affiliate, have failed to recognize that within the agency operations are valuable ingredients for furthering the community organization process. Some agencies, it is true, have developed community organization departments with specialized staff. Even here, one may question the extent to which the direct-service workers are related to these departments — or how these departments are related to central planning for the welfare of the broader community.

The community organization process is conceived here to be distinct from community organization as a method of social work practice. Community organization process comprises four basic steps which, when consciously linked, offer a rational approach to planned change. The stages of the sequential process are important activities which all direct-service agencies should undertake routinely: definition of the problem; assessment of facts concerning the problem; development and implementation of a plan of action; evaluation of results. The first three merit elaboration here:

1. *Definition of the problem.* — First, gather data on service lacks. Every direct-service worker goes through a diagnostic process within the limits of his own discipline to identify problems and to develop an appropriate treatment plan which will include use of his own agency's services and of those available in the larger welfare community. Lacks or inadequacies become apparent as a worker attempts to meet the needs of an applicant for whom the required service elements are unavailable.

As workers find themselves frustrated because of the lack of a needed service, they require a channel for communicating this lack in a formal and responsible manner; for a worker's knowledge becomes significant only if it is communicated and acted upon. Yet, the usual agency statistical reports of services given relate what was done, not what was impossible to accomplish. A responsible attitude toward persons untreated or inadequately cared for because of lack of resources dictates a comparable recording of services needed but not given, and the reasons for this discrepancy: Were the services nonexistent? Was intake closed? Was quality deemed inadequate?

I propose a reporting system which would prove functional to the operation of the direct-service agency and to community planning. It would involve the worker, at the level of problem diagnosis and treatment plan; the supervisor, in discovering gaps in worker knowledge or use of existing resources; the administrator in analyzing the composite experience of all workers; the board and directors, in recognizing implications for agency program or policy changes or the need to refer problems to a central planning organization.

This undertaking calls for reorientation of public and voluntary agency staff and of board perspectives from a parochial sense of responsibility for services performed by their own agency to an active concern for improving services in the larger health and welfare system. It involves staff knowledge, not only of existing resources, but of potential services which make up a full complement of resources required to maximize the speed and quality of the agency's particular type of human rehabilitation. The very acquisition of this knowledge and its outward reach would help create an agency sense of "community-centeredness." Such a scheme demands worker education, both in-service and across agency lines, possibly under the auspices of a central planning council which is problem-centered rather than agency-service-centered. It also requires other administrative supports in relation to supervision, reporting systems, and feedback to workers on the findings and their use by agency and community.

2. *Assessment of facts concerning the problem.* -- Before any use could be made of such data on unmet service needs, obviously it must be analyzed. Presumably it would yield definitive information on the numerical extent, the geographical clustering, and the personal characteristics of the persons in need of particular services at a given point in time. Continuity of such reporting would also reveal significant trends, both in changes in client need conditions, and in new knowledge acquired by the worker about services required. It could have the effect of pointing up the lag between what the professional knows and what he does.

Evaluation of this data would draw on approaches developed in Philadelphia, Pittsburgh and Milwaukee to determine priorities of need.[4] Thus, account would be taken of the various unavailable types of resources, the consequences of such lacks, and the feasibility of achieving change. Clearly these decisions involve value judgments. What is projected here is the application of these judgments at agency level by boards and staffs concurrent with, or prior to, similar evaluation at the community-wide level of planning. Implications deduced for interorganizational relations or for agency program redirection might be set in motion by an agency without involving central planning body staff time.

A counterbalance to recognized risks would be provided if the raw data were also communicated through a central reporting system to the council or other central planning body. The processing of welfare data by electronic equipment would make this feasible and, in the long run, more efficient and less expensive than the traditional and infrequent community surveys. Statistics of services given are often outdated by the time they are available, and also meaningless for the identification of service lacks. This proposed central reporting system has the added advantage of making known to the planning agency the identity of all agencies with a common and expressed concern with a service problem. It offers the central planning body the basis for undertaking research in depth on specific problems pinpointed by facts about actual people, rather than forcing it to rely on selective probes or educated guesses.

3. *Development and implementation of a plan of action.* -- Suffice it to say here that my projection contemplates communications of agency-identified problems to staff and board through meetings and written reports for policy action. Our immediate concern is with agency responsibility for community action on identified problems that involve forces external to the direct-service agency. As I see it, the agency has three alternatives: (*a*) to refer the problem to an appropriate planning body; (*b*) to intervene through the creation of an appropriate planning body when none exists; or (*c*) to intervene directly by establishing a new or changed community service.

In the first instance, it is seldom sufficient for an agency just to refer a problem to a planning body. Its staff and volunteers must be prepared to participate in the planning process as required through expert consultation, committee membership, research, interpretation of the plan to the community, and integration of the plan into the work of the agency. Many a fine plan has broken down through lack of agency cooperation in its implementation. Agency structure which includes board and staff committees on social action facilitates this function. Agency activities may range from developing new referral procedures to negotiating agreements for purchase of service, instituting actual changes in the agency's program, or taking legislative action.

These consequences for an agency are equally operative in the two alternative ways by which agencies can intervene in planning. These other ways, however, add steps to the process and thus make special demands on staff time and skills. To stimulate the creation of a neutral planning body where none exists, is an appropriate agency action when an identified problem is the concern of multiple organizations. This is especially true if it cuts across areas of specialization or lies outside the welfare field.

What are these added tasks? What special knowledge and skills do they require? An overly simplified statement would include such steps as: identify interested organizations and individuals, bring them together to define organizational purpose and to establish an administrative framework for the planning body, including its staffing patterns. In truth, there is nothing simple about this activity. It is fraught with problems of conflict of interest, personal, professional, and organizational; personality problems; and financial hazards. Special knowledge of organization behavior and of administration and skill in intergroup relations is demanded. However, since the function of this newly created organization is to plan, and not to operate a direct service, the chance of achieving this goal on a cooperative basis is relatively good. Consultation with the community organization staff of a national organization may be useful.

By far the most complex and difficult method of agency intervention is to take direct action in establishing a new service or changing an existing one. Added to the normal complement of interorganizational relationship problems, the agency now invokes suspicions on the part of other operating agencies as to its motives. If the new service is to receive referrals, and win necessary community support, the procedures used in its birth are crucial. For example, the shiny new hospital for the chronically ill, the well-equipped rehabilitation center, the badly needed day-care center, whether organized by a department of government or by a voluntary agency with governmental or foundation support, often fails to serve its intended clientele and may operate well under capacity. Expert knowledge of program and administration of such services are not enough. Needed is community organization expertise in the assessment of need; the shaping of program and organizational structure so as to take account of sociocultural, economic and political factors, community organizational history, ecology, leadership and centers of power; and the achievement of interorganizational supports calculated to provide a source of clientele and other needed resources. Indeed, it may call for establishing a research-demonstration program with built-in controls for measurement of success and for eventual continued support. Or it may require legislative action or public appropriation or the newly developing skill of "grantsmanship."

The decision-makers essential to the success of a particular project must be not only identified but helped to discriminate among alternative plans. For example, it will be necessary to decide whether to add a service to an existing agency or to create a new agency. In this process, research, interpretation, negotiation, compromise, and even the considered use of conflict may be brought to bear. In short, direct intervention in establishing new services is a questionable undertaking unless a qualified community organization specialist staff is available. It becomes a legitimate direct-service function only when the other two alternatives are ruled out as possible courses of action. A crisis situation in an area with no central planning body might well demand such agency action and responsibility.

It is my belief that enhancing the community work functions of the direct-service agency will have significant results for community planning:

1. Greater agency awareness and program response to community problems

2. Better working relationships between agencies and planners

3. More effective agency involvement in social policy and social action

4. Less conflict, competition, or confusion of community organization roles and responsibilities

5. A consultant role for central planning bodies

6. The expectation by member agencies that national agencies will provide standards and guidance on methods, and staffing patterns to carry out community work functions, including data collection pertinent to planning and ways of linking the agency to the work of community planning bodies.

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[1] Research supported by a training grant from the Office of Vocational Rehabilitation, U.S. Department of Health, Education, and Welfare.

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Community Resources and Protective Service Work in Child Welfare

Steven I. Pflanczer

A general problem in protective services

As a consequence of recent nation-wide interest in child abuse and maltreatment as a social problem, renewed attention is being paid to the training needs of workers who are active in this difficult and sensitive form of public service. To meet the increased demands put upon their workers, the protective units of Social Service organizations need training materials for their short-term or in-service training efforts. This paper represents a limited response to such needs. Its purpose is to articulate a general framework within which the use and development of community resources may be explored with protective service workers in public welfare who have county-wide responsibilities for child abuse and neglect cases. To reassure as well as to guide on-going service efforts, it is useful to try to make explicit the formal structure of services that enables participants in training workshops to identify those relationships between client needs, agency policies, and professional standards of practice which are amenable to change in their own agencies.

For county departments of social services, protective work in child welfare is a mandated service that is, procedurally and substantively, circumscribed by law. Virtually everything which workers are expected to do may become evidence in court and involve agency liability. Their work with child abuse and neglect cases combines legal controls with social services within two general types of service activities:

1. speedy, *short-term intervention* in crisis situations, and
2. intensive, *long-term services* to several principal clients.

In the light of their "open" mandate to serve all cases which are reported to them, both of these activities of protective service workers require a coordinated system of helping efforts throughout their service area in the county. In a general way, an adequate system of service delivery depends upon

1. *a well-trained and experienced workforce* which can meet the short-term needs of prompt intervention in crisis situations: professionally competent decisions have to be made whether a child or children may safely remain with their parents;

2. *an adequate system of caseload management* which is capable of meeting long-term service needs: children may remain in, or return to their families only if workers can exercise reasonable control over services which ultimately warrant such decisions;

3. *a coordinated system of outside resources* which supports both the short-term and long-term service inputs of workers: there is no service technology which could readily dispense with the need for "community" resources.

These are ideal requirements, of course, which very few service units can meet--especially in public welfare. In reality, the professional qualifications of the workforce tend to vary, caseloads are difficult to control, and many of the outside resources are simply not available. Most protective service units tend to operate under more or less taxing conditions of scarcity. While each has its own way of coming to terms with local conditions, however, it is important that pragmatic accommodations be sought on a reasoned basis within a general scheme of expectations about the division of labor in their agency. This is particularly true of relative responsibilities with regard to the use and development of outside resources.

Within certain limits of tolerance, it is the primary responsibility of agency executives to promote, maintain, and protect both the general mandate and resources of their organization. Managerial and supervisory personnel are, on the other hand, expected to specify agency policies of who shall do what and in what general manner for the clients of the organization. Service workers in turn are primarily responsible for all direct service contacts and tasks with clients. (10) These general notions can provide useful guidelines for the clarification of relative responsibilities with regard to the use and development of "community" resources. In the absence of clear understandings about them, both morale and services to clients tend to suffer. Some workers are likely to meet only the more or less vaguely sensed expectations or procedural requirements of their jobs.

Others are tempted to pursue unrealistic notions of resource development while neglecting the immediate needs of their clients. The general significance of such on-the-job reactions to service conditions derives from their potential contribution to what is known as creaming: a general process of rejections and referrals of clients throughout a service system which is experienced by them as an obstacle course that only very few can negotiate with benefits. (8)

Creaming as a process is, of course, generated by both private and public service organizations in a given area. It is an undesirable, and in part unavoidable consequence of a basic fact: very few welfare organizations' internal resources alone are sufficient to provide comprehensive services for their clients. Whether public or private, service units and agencies are always part of a larger scheme of helping efforts and must to some extent rely upon others. To the extent that they do so, they are part of each other's "community" resources. In fact, private agency personnel tends to be somewhat more free to refer applicants to public agencies which are usually mandated to serve them. It does not follow, however, that either public or private agencies have a greater responsibility with regard to the development of "community" resources. What their mutual dependence upon each other means is that no direct service organization can safely disregard the need for participation in community development and organization. (1,11) This is the general background for the practical question of interest here: *what should be the relationship of protective service workers to the use and development of community resources, as part of their direct service responsibilities for abused and neglected children in public welfare?* The pursuit of a general answer to this question, however, requires a clarification of the notions of both community and resources. In common usage, "community resources" are often taken to mean too much and too little--at the same time.

Notions of community and resources

The word *community* is a powerful symbol of association between people. It stands for close social ties, a sense of belongingness to something bigger than the self, and a source of security and identity which most people value. Because they are highly valued, communal ties are often claimed for people of the same race ("the Black Community"), ethnicity ("the Italian Community"), religion ("the Christian Community"), occupation ("the Business Community"), or of the same locality ("Our Community"). Whether factual or merely imagined, community characteristics and claims are real in the sense that people tend to respond to them. The de facto relationships of "their" community are parts of the very substance of their lives. The images of their community are expressions of their strivings and aspirations, measuring rods of how well they are doing, and justifications for what they are doing. A community is all of these things: a "living image," *i.e.*, a mixture of facts and fancy. (9,12)

Since people can participate in, or respond to the image of many communities, *the local or territorial community* is often invested with a measure of social completeness which enables *all* of its people to pursue their ends. The local community is seen as a complete social unit where the routine problems of daily living can be solved by all for at least a year, if not for a lifetime. This is, however a "living image", again, and it is important to distinguish between the reality and the image of it. The proud residents of a local village, township, or city often have to complete the social completeness of their local community by meeting some of their needs in a larger local area or in the entire county. If and when they can do so, they have a community of their own that is different from the local community of their residence. This is an important distinction for all--including protective service workers and their clients. Similarly, a local community resource may mean a lot to some residents of the village, township or city and practically nothing at all to others--including protective service workers and their clients. For workers and clients, these distinctions mean the difference between the use and the development of community resources. Clients can be helped to use only those resources which both objectively and subjectively exist for them. Others will first have to be developed for eventual use by them. It is equally important to understand, however, that community resources emerge from all kinds of actual involvement with others and the *organized* community resources of a local area, with or without fixed boundaries, are only one major form of them.

Since resources in general are "anything that satisfies a need," a more useful definition of resources must be derived from the identification and classification of basic human needs. While that may be attempted in several ways, (3) the purposes of this discussion can adequately be served by a general list of basic human needs for *love, status, information, goods, services*, or *money*. (4) Since all of these are controlled by other people, resources are people who can in one form or another, provide love, status, information, goods, services, or money for those who don't have them, who don't know how to obtain them, or who are confused about choices or priorities with regard to them. The list is adequate, for it can help make explicit the basic structure of social services: people are negotiating their lives through a more or less orderly and complex exchange of resources, and social workers are at times called upon to participate in that. The substance of the worker's daily concerns is *how to bring about an adequate matching of needs and resources:* how to increase the rate of participation by others in the life of the client. An important part of that is to know, of course, *how to substitute one resource for another.*because needs can be satisfied through an effective management of various resources: some people are more likely to provide love than money, information gained from some involves less loss of status than from others, and goods obtained from some will not substitute for love, etc.. While the concrete tasks performed by the worker in the course of managing resources make explicit the general structure of services to clients, their specific nature depends upon the social completeness of the clients' community, on the one hand, and upon the clients' physical and social distance from other resources beyond it, on the other.

Conceptually, the *client's community* is an analytical construct of a private world which the worker has to explore and reconstruct during her association with the client. In reality, it consists of those people and ways of doing things through which the client actively seeks to meet her needs for love, status information, goods, services, or money. The client's community consists of the *informal* resources of her own family, relatives, friends, neighbors, etc., and of those *formal* resources of groups and organizations which she knows how to use in and around her place of residence. What the specific resources of this community are must be *determined by the worker in cooperation with the client*. This is so, for it cannot be taken for granted that the client's community is coextensive with the resources of either the local community, the local area, or the county. . In fact, some clients are social isolates by virtue of being newcomers, for reasons of discrimination by others, or by choice--they have virtually no community of their own. Others might have only a few relatives or friends and might be able to use only some of the organized resources of their village, township, city or the local area around their place of residence. Neither is it necessarily true that either the local community or the local area and the county are socially complete in the sense that all of the client's problems could routinely be solved within them. *For clients as well as for others, the resources of the local community, the local area, and the county are only complementary but not necessarily complete.*

Direct service workers in the socially incomplete worlds of the local community, the local area, and the county must, of course, come to terms with the physical or social distances which might separate clients from community resources. The problems of *physical distance* from the client's residence to parts of the local community, the local area, and the county are well known problems of transportation not requiring elaboration. Any resource beyond reasonable walking distance might as well not exist at all for some clients in some situations. The notion of *social distance*, on the other hand, denotes a somewhat different problem of using community resources. Such organized resources as the facilities and servicesof clinics, counseling centers, schools, etc., might evoke in clients not only fear of the unknown but also hostility to people and ways of doing things which might increase the client's social distance from virtually everything that the worker attempts to provide as a resource. Social distance tends to distort perceptions which are at times vigorously supported by the client's immediate social circle--with or without actual experience with the resources in question.

Because of the combined effects of physical and social distance between clients and resources throughout the county, it is useful to develop a service perspective on resources that is based upon *the client's evolving ability* to use them. Some can be used by her almost immediately. She can learn to use others with relatively little assistance. Still others can be provided for her onlywwith considerable effort or not at all. Although one kind of resource might often have to be substituted for another, there seem to be several advantages of thinking about clients and resources in this manner.

1. Resources which can be *used immediately* are the handmaids of crisis intervention; they sharpen the worker's sense of where to turn and what to do first.

2. Sustained service, on the other hand, is to evolve on the basis of those resources which *the client can learn to use* with relatively little assistance; they sharpen the worker's sense of the actual flow, or sequence of services.

3. Finally, *resources which require great investments* of time and energy provide a realistic sense of the most pressing developmental needs for resources for which no alternative can be found.

Briefly, a service relevant scheme of resource utilization and development might help structure the on-going flow of services under less than ideal conditions.

A scheme of resource use and development

Chart I shows a *general scheme of resource distribution* that anticipates the needs of protective service units in child welfare. The scheme is based upon service activities recognized by the New York State Central Register of Child Abuse and Maltreatment which may become part of service plans developed by county departments of social services. Its purpose is to provide a general framework within which both on-going resource use as well as resource development may occur. The basic assumption of the scheme is *that service delivery is resource management under conditions of scarcity:* the detached worker approach--caseworkers traveling the highways and by-ways of the county from client to client--is an expensive form of service which requires an extensive *delegation* of service tasks. In principle, service tasks may be delegated only under two conditions: 1, when others can perform them just as well as the worker or the service unit could, and 2, when others can perform them better than the worker or service unit could. Based upon this principle, the scheme identifies *three principal zones* of resources at generally increasing physical and social distance from the client's community, *i.e.*, her family, relatives, freinds, and neighbors. The *first* zone consists of those resources in the client's community which are usually needed for immediate relief in her homelife and for the protection or treatment of children and adults in the family. The *second* zone refers to those resources which can be put to use by the worker as a member of an organized service unit in an agency. The *third* zone consists of those organized resources of voluntary groups and formal organizations which might be available throughout the service area of the county. While each of these zones has its own special problems, they cannot adequately be solved independently of each other. It is across these three zones that workers are to perform tasks which cannot be delegated to others or make referrals to both the first and thrid zones of resources as a matter of services to clients. In the light of prevailing client needs, agency policy, and professional standards of practice, *resource management* is a reasoned process of substituting one resource for another under existing conditions of scarcity. *Resource development* is, in turn, guided by recognized service needs for which no acceptable substitute resources could be found.

Inasmuch as resource management by the worker is to occur from an intermediate position between the resources of the client's community and organized community resources beyond them, failure to delegate in either or both directions increases the demand upon the worker's own resources. This is the most general reason for viewing the *identification and mobilization of resources in the client's community* as an essential part of the general structure of services. In addition, the worker's own agency and other organized community resources can only complement rather than replace the primary resources of the client's community. The superior scale and scope of organized efforts to help people are usually achieved at the price of increased social distance from potential clients; organizations tend to be more effective with realtively routine rather than unique needs and events which call for prompt and individualized human responses. Neither can the technology of human service organizations easily dispense with the need for the client's own community resources. By contrast, the delegation of authority for involvement by relatives, friends, neighbors, and other "indigeneous" parents aids or homemakers is to be explored because of *the client's relative closeness to them* for certain services in what is a unique and more or less protracted crisis which might result in the loss of her children. Members of the client's community can, under the supervision of the worker, perform the very valuable role of "common messenger" between the client's world and the larger community represented by the worker. They can, for the same general reason, provide their own homes as a "change inducing milieu" for the temporary day or foster care of children (6,7). All of this requires, of course, *intensive efforts by workers in the field* and points to management problems for supervisors in the agency.

While it hardly needs noting that even intensive search for resources in the client's community might fall short of expectations, *the need for organized community resources* is quickly made obvious by the presence of certain types of clients in a caseload. Socially isolated families, particularly hostile or criminally liable parents, and severely retarded or disturbed mothers have only meager or no community resources of their own at all. It cannot realistically be assumed that the needs of such clients can be met by the average protective service worker alone. In fact, the protective service needs of most clients must fit into *a competitive framework of exchange relationships* between special-purpose voluntary groups and formal organizations through which organized social services are developed and made available to people in need (5,3). A local village, township, or city may, however, lack the essential ingredients which are needed to establish and maintain such organized community resources: funds, personnel, and clients. Under those conditions, *service referrals are matters of mutual advantage* between a limited number of service groups and organizations which must in fact control the scope of their services while they are at the same time competing with each other for funds, certain types of personnel and clients. The now fashionable slogans about advocacy tend to reflect a somewhat tongue-in-cheek, or belated recognition of this fact; the delegation of service tasks between organized community resources has its own problems under conditions of scarcity. Beyond the immediate need to substitute one existing resource for another that is not available, the pressing problems of workers might at least in part be alleviated by the *standardization of service relationships* between existing organized resources. Standardization means explicit understandings or formal agreements about conditions under which one agency's clients may become eligible for services by another. Since there are considerable differences between individual workers in terms of their ability to develop personal networks of inter-agency referral, the standardization of service relationships is likely to enhance their *skillful use* of organized community resources that is part of their function-specific responsibilities for direct services. The development of purely personal networks of referral tends to be a stop-gap practice rather than genuine resource development in the organized community, and its shortcomings are, no doubt, obvious in agencies with relatively high rates of workforce turnover. Within certain limits of tolerance for special assignments, the maintenance of an up-to-date inventory of organized community resources, the standardization of their relationship to the workers' agency, and the development of newly organized resources are legitimately viewed by direct service workers as supervisory and executive responsibilities in most public agencies.

Although the service scheme explored here distributes the worker's activities across three zones of resources, the use of client community and organized community resources is predicated upon the worker's own service skills and competent management of the protective unit's *internal resources*. Inasmuch as the direct service skills of the worker are conditioned by the combined effects of the unit's "open admission" mandate, wide geographical dispersion of clients, legal-administrative requirements, etc., the use and development of resources depends ultimately upon competent caseload management. By *caseload management* is meant a reasoned and systematically monitored process in which contacts with clients and outside resources are a function of service priorities based upon the needs of *all* clients to be served by a unit. Since service priorities are difficult to set if each client is treated by workers and supervisors alike as a separate case with a unique sequence of necessary contacts, the alternative is a form of *team approach which allows a double triage* of matching the differential skills of workers with differential case characteristics. A modest form of team approach, or principles derived from it, might well be within the reach of all protective service units. It requires only the identification of a few, locally relevant service variables and a relatively simple technology of management.

Since the work of protective units combines legal controls with social services, a distinction between *investigative and service functions* may provide a criterion for triage of clients and workers.

In short, "court-bound" and "service intensive" cases may be identified either for handling by especially selected workers or for assignment to undifferentiated caseloads. The same is true of *various service sites, i.e.,* territorial clusters or "natural areas" of clients and organized resources in various stages of standardization throughout the county. Subsections of the county with known resources but at varying physical distance from the agency are relevant for making assignments to undifferentiated caseloads as well as to caseloads of special units. A third criterion may be derived from *time limits* which result from the internal dynamics of cases and from procedurally set deadlines. Since time limits tend to be related to "paperwork," special measures might have to be taken to separate "service-relevant" and "systemic paperwork." An initial analysis of, and sustained attention to the practical influence of such service variables upon what workers may or may not be able to do are essential parts of internal resource management.

Based upon these general considerations, it is possible to list some of the elements of a simple service technology which could support rational discourse about relative responsibilities with regard to community resources in and outside the agency/ As a minimum, the following should be maintained and be accessible to all service personnel within the agency:

1. a detailed *map of service sites*, or "natural areas" of service where clients and known resources tend to cluster throughout the county;
2. a cumulative *list of former clients, client-community contacts, and other volunteers* who could be approached again as potential resources for others based upon past experience with them;
3. an up-to-date *inventory of organized community resources* by service site or area, by type (voluntary group, or formal organization) and by type of service relationship (informal or standardized access);
4. a simple set of *monthly service statistics* (court-bound and service intensive active cases, terminations, etc.) by type of contacts (client-community, worker, organized resources) which is discussed and understood by all workers and supervisors.

While general appeals for resources and cooperation are often made in and outside the agency, neither operational nor projected service plans can effectively be prepared and met without *at least quarterly analysis* of such data. In spite of dedicated efforts by many workers and supervisors, the absence of such analysis usually means the absence of effective resource management--as a matter of overall agency liability. As to more specific responsibilities with regard to the use and development of community resources, public relations, and lobbying efforts, the institution of sound management practices and agency routines which support them are clearly management responsibilities. In the light of their heavy responsibilities in the client's community and of their own work which includes properly monitored service referrals, the mission of direct service workers should be kept within reasonable bounds--as little developmental work, by special assignment, as possible. This appears to be advisable for two reasons: 1, uncoordinated developmental efforts by individual workers tend to be uneconomical in terms of time and energy or to lead only to personalistic networks of referral; 2, the standardization of service relationships between organized resources requires higher levels of authority than what is usually granted to direct service workers. Finally, what workers are doing about resource development "after hours" are matters of enlightened professional interests or meritorious civic endeavors rather than direct service responsibility and the difference between them is real.

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* These references were selected for their potential value to other trainers who might wish to use this paper as part of their own training efforts. Asterisks denote articles which were shared with trainees as background readings.

Parent Rehabilitation and Enrichment Project: An Example of Community Agency Cooperation

Bernadette M. Ambrose

In response to the need for a treatment program for abusive and neglective parents, in 1973, the Schenectady County Child Guidance Center in conjunction with the Child Protection Unit of the Department of Social Services of Schenectady initiated a Parent Rehabilitation and Enrichment Program (PREP).

History

The New York State Child Protection Act of 1973 mandated that the child welfare division of each county establish a specific child protection unit. This unit was to handle all referrals involving alleged abuse and neglect of children. The State Department of Social Services also set up a 24-hour hotline. No funding was provided for training workers or for treating families referred to these units. Almost immediately, the child protection units were innundated with referrals. This created serious overloads for both child protection workers and the courts, resulting in general confusion.

Since the new law focused more sharply on the problems of parents, child guidance center workers determined that training for child protection workers and treatment for parents were primary needs. Using information gained from visits to demonstration projects in New York City, Syracuse, Springfield, Boston, and Portland, as well as research on other child abuse and neglect treatment programs, a small pilot program was outlined to meet the existing needs of this community.

Worker seminars

Child Guidance Center workers offered child protection workers a 10 week, 90 minute seminar directed at 1) increasing child protection workers' knowledge of the dynamics of abusive and neglecting parents and methods of treating them, 2) exposing workers to the proposed treatment program, and 3) involving workers in all phases of the process.

In planning the seminars, common reasons for failure of inter-agency work were taken into consideration. An attempt was made to forestall problems involving lack of mutual role understanding, tailored intake, and worker-agency rapport.

The seminars were small and informal. A knowledgeable and experienced instructor was selected who understood and respected the workers' roles. By encouraging an open exchange of ideas, the instructor attempted to establish a rapport with the workers while integrating both facts and skills necessary for working with difficult clients. This approach was chosen because child protection workers frequently are young and enthusiastic, but inexperienced and burdened with large case loads. The child protection worker's typical day is filled with multiple crisis situations. Such workers rarely have an opportunity to follow up cases referred elsewhere or to provide outside agencies with further data concerning a case.

Basically, child protection workers were taught the outreach approach to working with abusive parents, drawing on the work of Leontine Young (9), Ray Helfer (3), Irving Kaufman (2), and Sidney Wasserman(8). Later, Norman Polansky's work with ADC parents was introduced. His work particularly emphasizes pragmatic cas-work applications based on sound research with "hard-to-reach" families. An approach includes frequent home visits, short-term contracts with parents, the worker's awareness of self, and a more aggressive orientation toward the positive uses of dependency, authority, and other "outreach" tools in casework. In the seminar, workers would learn the dynamics of this approach and then broadly apply them in their contacts with and treatment of abusive and neglecting parents. The establishment of the treatment group for parents represented an operationalization of this approach.

Parent treatment group

Intake

Intake for the treatment group was tailored to meet workers' needs. Workers reviewed potential referral cases and used an especially designed checksheet to note pertinent points which merited detailed discussion with Child Guidance Center workers at intake. This eliminated time-consuming preparation of complicated summaries which were not really necessary in a group scheme. It also reduced workers' uncertainty and anxiety, by providing a direct, personal, concrete task. Child protection workers became a constructive part of the intake process, and received quick feedback as to whether their referrals would be accepted into the group.

Treatment

After parents were accepted as potential group members, child protection workers were asked to visit them over a 3 month period to establish good rapport through frequent contact. Training seminar guidelines were followed. Home visits were to be brief, frequent, and nurturing; they were aimed at reaching individuals who were really "turned off" by traditional casework approaches. All home visits were jointly supervised by MSW's from both agencies.

Child protection workers were requested to keep a small notebook in which the dates of visits and one or two word comments concerning them would be recorded. The notebook was used in supervision and as a reminder of contacts and general discussion.

Child protection workers were given copies of a letter of invitation from the Child Guidance Center describing the group. When rapport and trust began to develop with a client, the child protection worker would invite him to join the treatment group. If the client expressed a decided interest in the group, one of the invitations was presented to him. Group attendance was to be strictly voluntary, due to the basic mistrust of outsiders commonly encountered in abusive individuals.

From the beginning, parents were viewed as the primary clients. The early dependency needs of abusive and neglecting parents were never adequately fulfilled and they are essentially children psychologically. For this reason, parenthood represents an ongoing crisis for them. Therefore, in treatment, it is necessary to "start where the client is."

The focus of this program was on the parent, especially the mother, who is usually the only parent

in an ADC family. If the cycle of abuse is to be broken, parents need to be reparented. The theme of the project was Parent Rehabilitation and Enrichment (PREP). It is assumed that if the parents' needs are met appropriately, they will meet the needs of their children naturally. OUtside coercion is thus replaced by self-motivation. This is desirable since, as Elizabeth Philbrick of the National Center for Child Abuse and Neglect put it, "Kids want their parents to meet their needs, not social workers." (4) The primary goal of the treatment program was to help individuals function more effectively, specifically as parents.

Workers were to become natural role models for participating parents. Hence, nurturing, supportive intervention aimed at building the trust that is sorely lacking in abusive parents was stressed.

The treatment group began in September 1973 with 7 mothers. The meetings were held in a non-clinical environment where mothers would feel comfortable, a daycare center near a local bus route. These women and their pre-school children were brought to the daycare center by their individual workers. This was the weekly routine until mothers would come freely to group meetings together or with other parents, children, and child protective workers. Workers used the parents' dependency positively to encourage mothers to form groups.

As the treatment group progressed to a state of basic trust (1) during the first 3 months, isolation patterns began to change. A second day of task involvement was begun. The group met at a local drop-in living center which is devoted to helping parents improve homemaking and inter-personal skills. The drop-in staff actively cooperated with the program. Child Guidance Center workers met mothers there initially and showed them around. Transportation was initially provided by child protection workers and child care for pre-school children by the Child Guidance Center. The children could walk in and out freely to see their mothers.

The parents' relationship with Child Guidance Center workers and their involvement with the Department of Social Services and the Living Center were aimed at breaking up predominant patterns of isolation and encouraging the parents to commiserate with others who have similar problems, and introducing parents to problem-solving techniques. These experiences coupled with growing competency in homemaking skills enhanced the parents' self-esteem.

The daycare center staff also worked closely with us. As the group progressed, many of the children were placed in daycare at this center. The parents felt they were a part of the daycare center while meeting there each week, and the staff worked to creatively involve parents in the daycare routine. Mothers were invited to lunch, given work at board meetings, and asked to help with various tasks. The director had a good understanding of this kind of parent and helped the staff to become aware of these children's special needs. The children also benefited immensively from being in a more normal child-centered environment. This was evidenced by their rapid developmental growth in areas of speech, play, and interpersonal competence. This arrangement also provided group workers with constant feedback on the home environment through daily observance of the child and gave further support to a fragile family structure.

Results and evaluations of parent treatment group

Both of the participating agencies had reservations about the process. These were the most resistive clients, isolated individuals, people who could not ask for help and who usually refused aid when it was offered. Furthermore, this was an experiment sandwiched in between many other work responsibilities.

At the end of a year, it was evident that PREP was an effective means of motivating and treating "hard-to-reach" parents. Although it had proved very difficult to motivate fathers or get a treatment group going for them (their work schedules often made a fostering relationship with them impossible), 6 of the initial 7 mothers maintained excellent attendence during the first year, and continued to do so for over 2 years. No major incidents of abuse had occurred among participatns in the program. There was also a noticeable improvement in the social functioning of the parents at home and in the treatment group.

The parents who were originally isolated, angry, and mistrusting had become much more outgoing, friendly, socially adept and better at homemaking. On an interpersonal level, these women became more assertive, learned problem-solving, made new friends, and, most importantly, had demonstrated the ability to ask for help in a more appropriate manner. Crisis lessened, group became an important function, and friendships developed. A secondary result was the increased involvement of parents on an individual basis with other agencies and programs such as WIN, Tutorial Reading, Parent-Child Development Project, Infant-Stimulation, and Child Guidance.

The program also had several effects on workers. It gave them hope. It proved to them that despite the stress under which they work, it is possible to learn more about their clients and to become an important part of the treatment process. The workers also were given the opportunity to establish a rapport with very mistrustful clients and gain the satisfaction of seeing their continued efforts bring about positive change. For the dubious child protection workers, the program was a verification of their work with clients and of the skills and knowledge gained in the seminars.

Community involvement

The agencies involved saw this mini-project as a "good marriage", providing truly complementary services. Through public information meetings, the child protection supervisor was able to involve local community groups such as the American Association of University Women and the Junior League in helping to examine the needs of area families and to explore the ways in which community agencies could be helped to meet these needs. From these community contacts, a Child Protective Advisory Council was formed. These interested citizens provided input for several other related projects, e.g., volunteer home visitors, a Child Welfare Design Committee working through the Human Services Planning Council to help meet the needs of "hard-to-reach" clients. Several grants were written to obtain funding for these necessary services.

In the fall of 1974, the AAUW in cooperation with the Northeastern New York Chapter of the NASW sponsored a joint Child Abuse Seminar with the goal of making the total community aware of the problems and needs of service agencies and their clients. Leontine Young, author of *Wednesday's Children* was the main speaker. Over 500 people attended the seminar, including physicians, lawyers, teachers, nurses, social workers, and community workers from the greater capital district.

Non-verbal treatment group

As the Child Protection Agency and its "hotline" continued to monitor calls, it became apparent that the needs of neglectful parents easily outweighed those of the alleged abusive parents in Schenectady County, in fact, 9 out of 10 complaints were in reference to the alleged neglect of children.

Establishing a program for this group was recognized as being more difficult than the earlier task since attempts to involve non-verbal, neglectful parents in treatment programs have been largely unsuccessful. However, the child protection workers were eager to try and displayed even more enthusiasm than they did with the original program.

We agreed to follow the same approach of working together once more, this time recognizing the need for group treatment for neglectful parents. Again the Child Guidance Center staff ran 10 week, 90 minute seminars, this time focused on neglect. The target group was the most difficult and unreachable clients on the workers' caseloads--the multi-problem families who often get shuttled from one agency to another, but always come back to the attention of the Department of Social Services and Child Protection.

Polansky's work, *Understanding Child Neglect* was tailored to the Child Welfare Worker, and by teaching his 5 syndromes of ADC neglectful mothers and infantile personalities, the workers' diagnostic and treatment tools to deal with neglect were sharpened. Such knowledge enabled the worker to realize that perhaps the only form of initial relationship possible for many of these clients is a clingingness that is essentially self-centered and indiscriminate. (5:17) Polansky shrewdly observed that if the worker can overcome fears regarding involvement with and separation from such clients, an awareness of this kind of attachment can be the beginning of a bridge toward the establishment of true object relations. This is quite a finding, since it goes against the traditional policy of "fostering dependency," and instead makes positive use of the dependency that is already there. It becomes the catalyst to healthy involvement that leads to a nurturing relationship and later to independent functioning and eventually better parenting.

Casework is talking treatment, Polansky observed, and this client is turned off to it--verbally inaccessible, so the child protection worker must reach her by concrete aid--money, clothing, schooling. This persistent interest in a pragmatic way leads first to a relationship, then to verbal accessibility, and finally to better functioning. Workers teach clients by serving as role models of good parents. This technique not only helps the worker to increase the client's verbal accessibility, a preliminary to casework treatment, but as Polansky noted, it also constitutes a type of treatment itself, and as such has curative value; As demonstrated by Polansky, et. al., this approach leads to further ego integration and better parenting, arresting the cycle of neglect.

The primary aims of this treatment program were to socialize the participants to the point where they would be able to join a verbal problem-solving group, or to increase their verbal accessibility (6) and thereby improve their functioning as individuals and parents. Towards these ends, enrichment and rehabilitative activities were to be the main focus of the program.

The milieu in which this was to take place was carefully mapped out. Again the parents were to be the center of attention. The steps of inclusion were designed to insure progressive success in a warm, non-threatening environment which involved no competition, achievement orientation, or solo achievements such as talking. Each mother was to be able to move at her own pace.

Living Center staff were able to meet this need by planning small group (3-8) tasks, which could be easily completed, and which would produce some tangible weekly result such as cookies, stuffed animals, flower arrangements, beads, etc., which could be taken home by each client. The group met on Friday mornings from 9:30-11:30.

The original population referred was 25 mothers; there were only 2 fathers in all of these homes.* After 3 months of outreach work by child protection workers, 13 mothers came to the group, a good first showing. Individual workers brought the mothers and children. The Center was located atop an old school building. Mothers arrived scrubbed and groomed like children on the first day of school, clinging to workers and wondering what was to happen next.

PREP A group members helped workers greet each new PREP B member. This was a real ice breaker. Two MSW's from the Child Guidance Center, two second year graduate social work students (State University of New York at Albany, School of Social Welfare), and 2 child protection workers, each in male-female combinations, comprised the treatment staff. Our job was to go from group to group, working at tasks with parents, and to view the children in the nursery, while creating a milieu that was free and open. An environment was created in which parents could relax, be involved in appropriately interesting tasks and gradually come to perceive the workers and teachers as non-threatening figures to whom they could relate if they so desired.

It was estimated that 6 months would be necessary to establish a sense of basic trust and move on to authonomy in the group. Surprisingly, many mothers reached this stage in less than 3 months. In fact, at the first meeting, the child protection and Living Center staff had been prepared for a group of verbally inaccessible mothers and, much to their surprise, there was a great deal of conversation among the mothers--a phenomenon due perhaps to anxiety, since the weeks that followed were not as noisy.

This group was in many ways reminiscent of a settlement group work model. Being in an old school which housed the WIN program, Adult Basic Education, and an open school, the Center was in an ideal location for the creation of a learning environment. The mothers began to bring their friends on non-group days and referred to the program as "school." In many ways it was a school, and although several parents lived right in the neighborhood and had never used the drop-in center, they soon learned to appreciate its offerings. The warmth of the homemaking staff was a further means of nurturing these mothers and the services provided such as laundry, sewing, cooking, budgeting, child-care, grooming, and "how to"courses were natural hook-ins to parents' needs. The mothers were undergoing socialization throughout the learning process. As they got to know the social work staff, they began to make many requests for varied services. It was wonderful to observe and be part of this process.

Later, a public health nurse was invited to spend the mornings with the group. Mothers gradually began to bring their children to see her and to discuss their health-related problems with her. Numerous referrals were made to other facilities such as the Well Baby Clinic. Through this means, isolation patterns were broken and verbal accessibility helped to enhance the clients' self-esteem as they learned new skills and developed confidence in their abilities.

Because of the type of groupwork used, a greater number of mothers could be offered this service. Initially, 25 parents were accepted, 3/4 of whom actually participated. After a few months, the popularity of the idea, coupled with the need, led to an open intake policy. A total of 40 families were involved in the first year, including 5 men. The goal of the group was reached by individual members at varying stages. The process of group involvement to a state of verbal problem solving is shown in the appendices.

This group proved to be an effective means of reaching neglectful parents, and it is still very active.

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The Interview

The interviewing process in both theoretical and pragmatic terms

Away with the "Bedside Manner"!

Sidney Jourard

Many nurses acquire a fixed way of behaving in the presence of patients which might best be called their bedside manner. Some nurses always smile, others hum, and still others answer all patients' questions about medication with the automatic phrase, "This will make you feel better." The bedside manner appears to be something which the nurse "puts on" when she dons her uniform.

As an observer in a hospital situation, I recently noticed some instances of the bedside manner which led me to wonder about the function of this particular pattern of interpersonal behavior. For example, I was in a patient's room, interviewing him informally about his background and current preoccupations, and on several occasions nurses entered the room to perform various "nursing functions." This man was seriously ill and had much on his mind, but his nurses came in talking cheerfully and did not cease the cheerful discourse until they had left. I had little doubt that the nurses knew no more about this man after they left than they knew when they entered. I verified this guess when I later asked the nurses to tell me about Mr. Jones. One nurse replied, "Oh, he's a nice fellow." The other told me, "He's O.K., though sometimes he's a bit diffucult." I asked both of them if they had any idea of what Mr. Jones had on his mind, and each said that *so far as she knew*, he was cheerful most of the time.

It became apparent that these nurses, who after all are not atypical, had "solved the human relations problem" in nursing by means of stereotyped modes of behavior. Now I would like to discuss the bedside manner in the light of more recent formulations of interpersonal behavior — its origins, functions, and connections with nursing care.

Interpersonal behavior is any and all behavior which a person undertakes in the presence of others. From a sociological point of view, patterned interpersonal behavior is described as role-performance, and it serves an important function in the social system (the hospital, for example) to accomplish the purposes for which it was organized.

From a psychological point of view, interpersonal behavior patterns are acquired as means for satisfying needs and for reducing anxiety. *Rigid* interpersonal behavior has been called "character armor" by some psychoanalysts (Reich, 1948). It serves the function of stifling spontaneity in the person and protecting the person from possible hurt coming from the outside. Character armor serves effectively to hide a person's real self, both from himself and from others. Character armor is acquired in situations marked by anxiety, and it protects a person from recurrences of anxiety — and from guilt-provoking impulses and actions.

Doubtless, the "bedside manner" warrants being regarded as an instance of character armor, since it is a case of rigid interpersonal behavior. It is acquired by a nurse as a means of coping with the anxieties engendered by repeated encounters with suffering, demanding patients. If her "armor" is effective, it permits the nurse to go about her duties unaffected by any disturbing feelings of pity, anger, inadequacy, or insecurity. It is as if the nurse, early in training, asked herself the question, "How should I behave in the presence of patients?" By trial and error, or perhaps through emulation of a highly esteemed instructor, she arrives at a "formula" which "works" for her. Hence, one nurse might habitually crack jokes, another might look and act hurried, and still another might "mother" all her patients on the premise that all patients are babies..

But let us look more closely at these stereotyped interpersonal behavior patterns to see some consequences to which they lead. We know that one person's behavior toward another is a controlling factor in the behavior of the other person. Thus, maternal behavior tends to "pull" dependent behavior from the other person (Leary, 1957). Joking behavior tends to evoke joking behavior in return from the other. Careful analysis of psychotherapy patients has shown that not only they, but people in general, are able to function most comfortably with other people when the *latter limit their reactions to some fixed range.* Some people are unable to cope with another's tears, some cannot handle another's anger, some cannot deal with another's sexuality, and still others cannot tolerate spontaneous expressions of despair. Unwittingly, they behave in the presence of others so

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From The Transparent Self by S. Jourard (c) 1971, 1964 by Litton Educational Publishing, Inc. Reprinted by permission of D. Van Nostrand Company.

that the others will find it difficult to express these threatening patterns of behavior. We may assume, then, that *one of the latent functions of the bedside manner is to reduce the probability that patients will behave in ways that are likely to threaten the nurse.*

There is, however, a consequence of rigid interpersonal behavior, such as is exemplified by the bedside manner, which can gravely interfere with the avowed aims of the nursing profession. The nursing profession is dedicated to the promotion of health and well-being in patients, to co-operation with the forces that abet recovery from illness. Nurses traditionally pursue these professional aims through such means as administering medications, providing physical care, and ensuring that standards of hygiene and physical comfort are maintained so long as the patient is in their care. No self-respecting nurse would overlook such vital information as the patient's temperature, blood-pressure, and other physical signs of progress or regress with respect to recovery. *Yet the bedside manner is nicely designed to exclude a highly important source of information that has much pertinence to the optimum response of the patient to treatment. I have reference here to information which can only be obtained through the patient's verbal disclosure of what is on his mind.* Just as thermometers and sphygmomanometers reveal something about the state of the patient's body — which nurses and physicians are concerned with — so does verbal self-disclosure reveal something about the state of the patient as a whole person. If the patient has something on his mind, it is possible, even likely, that this "something" may have direct pertinence to his over-all problem in health. Thus, he may be gravely worried, or he may have serious misconceptions about his illness, or he may know that he is markedly sensitive to penicillin. I know of several instances of people who nearly died because every time they tried to tell their nurse of their intolerance of penicillin the nurse replied, cheerfully and firmly, as she neatly performed the injection. "The doctor knows what's best; this will help you get well." Nobody listened. We may propose, then, that *another latent function of the bedside manner is to prevent a patient from disclosing himself, to prevent patients from making themselves known to their nurses (and physicians).* Rigid interpersonal behavior presumes that all people before whom it is enacted are alike in personality; to some extent, rigid interpersonal behavior actually provokes a certain uniformity in the behavior of others. But we know that, in spite of certain fundamental human similarities between people, they differ markedly one from the other. It is apparent, then, that *the bedside manner seeks to obliterate or to deny individuality in patients;* it unconsciously attempts to enforce a certain uniformity in patients' personalities, the kind of uniformity with which the nurse feels most competent to cope. It seems to be difficult for nurses (and others) to accept the fact that they cannot know any other person — patient, student, friend, or family member — *until they have taken steps to find out who and how he is.* Recently, professional nurses and nursing educators have become concerned with attempts to "integrate psychiatric and mental health concepts into nursing curricula and programs of nursing care." Translation of this weighty and worth-while assignment into achievable aims is problematic. It is well to ask, "What psychiatric and mental health concepts? How does one go about 'integrating' (or as one participant in a recent conference proposed, in all seriousness, 'homogenizing') these concepts into a curriculum and a nursing care program?"

We have proposed that one important concept, or precept, stemming from the experience of psychiatrists and mental-hygiene workers is as follows: "It is important to know the other person's 'self,' that is, how he is experiencing the world. It is important to know the other person's self because his behavior, and even his physiology, is affected by his 'phenomenal field.' Workers, such as nurses and physicians, who are committed to changing physiology from the pathological range to the healthy range are obliged to learn as much information about a given person as is pertinent to their aims. If they overlook information available only through patients' full disclosure of self, then they are, in a sense, possibly hamstringing their diagnostic and therapeutic endeavors.

"Let it be granted, then, that knowledge about a patient's 'self' is of value for medical and nursing care. But we have already shown that a stereotyped pattern of interpersonal behavior enacted by many nurses — the bedside manner — is nicely designed to prevent patients from disclosing themselves. It becomes apparent, then, that *the bedside manner can actually obstruct* (or at the very least not help) *attempts to "integrate psychiatric and mental health concepts into programs of nursing education and nursing care."*

Another concept, or principle, which stems from the broad field of mental health maintains that "real-self being" is an aspect of healthy personality. Neurotic people and people with the "socially patterned defects" whom Fromm (1955) and Horney (1950) described so aptly, are all persons who display varying degrees of "self-alienation." Concretely, this means that they have repressed or suppressed much of their own real and spontaneous reactions to experience. They replace their spontaneous behavior with carefully censored behavior which conforms to a rigid role-definition, or a rigid and highly limited self-concept.

They behave as they "should" behave and feel what they "should" feel. When roles and/or self-concepts exclude too much "real self," a person soon experiences certain symptoms, viz., vague anxiety, depression, and boredom, and if the person has come to neglect the needs and feelings of his body, then such physical symptoms as unwarranted fatigue, headache, and digestive upsets will arise. In short, failure or inability to know and be one's real self can make one sick. In extreme cases, where the real self has been well-nigh strangulated, it may happen that there is a "breakthrough," and the person suffers a "nervous breakdown."

People squelch their real selves because they have learned to fear the consequences of real-self being. I have observed that the nurses' bedside manner is not a faithful portrayal of her real self. Is it possible that the role of nurse, as this has been learned during training and in practice, is one which is detrimental to the physical and mental health of nurses? Is it possible that nurses, in their attempts to root out their own spontaneity, replacing it with stereotyped modes of interpersonal behavior, are actually doing violence to their own personalities and bodies? We may propose that *another latent function of the bedside manner is to foster increasing self-alienation in nurses, thus jeopardizing their own health and well-being.*

There is a connection between a nurse's inability or fear to be her real self while "on duty" and the blocking of patients' self-disclosure. Research and clinical practice show that one of the factors which promotes real-self being and honest self-disclosure in a person is an empathic acknowledgment of what has been expressed. Now, if a nurse is afraid and even ignorant of her own self, she is highly likely to be threatened by a patient's real-self expressions. Hence, a patient might send out a "trial balloon" concerning what really is on his mind, only to be encountered with a response from the nurse which effectively squelches him. A nurse who is more aware of the breadth and depth of her own real self is in a much better position to "empathize" with her patients and to encourage (or at least not block) their self-disclosure. The bedside manner, then, can blind a nurse to much of her own real self; the consequent reduction in insight then impairs empathy with patients. Empathy -- the ability to guess what a patient is experiencing in a given situation -- is an outgrowth of insight, or self-awareness. *The bedside manner desensitizes a nurse to her own experience and handicaps her attempts to know her patient.*

We have pointed out that the bedside manner was originally acquired as a kind of protection for the nurse: it kept her relations with patients impersonal and protected her both against becoming known by patients and also against any feelings she might have for patients which she believes she should not have. Suppose one could "strip" a nurse of her bedside manner, just as one could divest her of her uniform? If a person is proud of his or her body's appearance, nakedness will not be much of a threat. If a person is not ashamed of his real self, then disclosure of self should not be highly threatening either. But here is a paradox noticeable in the training of nurses. Beginning students, both in colleges of nursing and in hospital schools of nursing, begin their careers loaded with responsiveness -- real-self responsiveness -- to the experiences which confront them. They experience and sometimes express feelings of panic, disgust at excreta, shame at exposures of the human body -- the gamut of reactions which one might expect from naive late adolescents. They compare their own feelings and reactions with the examples provided them by their teachers and preceptors and find themselves "inferior." They may even be directly told, "Nurses don't feel like that." Now, in time many of the initial emotional reactions undergone by beginning students will change. The initial shyness in the presence of another's nakedness may change to frank acceptance of nudity. As the girl matures and has more experience with a broader range of human reactions (her own and those of others), her emotional responses to giving injections or enemas may change radically from what they were early in training. But this "real-self" change will not occur unless the student nurse has been able to acknowledge and express her feelings openly and test all of her expectations with regard to the provoking experiences. If the student has been obliged to deny to her instructors and to herself that she has certain feelings, then she may eventually become ashamed and afraid of her real self. Consequently, she suppresses and represses her honest reactions and replaces them insofar as she is able with what she believes she "should" feel. In time, following the role-models available to her, she becomes a nurse with a squelched real-self and a contrived bedside manner. It seems likely that the bedside manner which we have been commenting upon is a direct outgrowth of the instructional period in school or college and the apprenticeship period when the student is watching how experienced nurses carry out their work. Stated another way, it seems very likely that students actively learn and are actively taught to be estranged from their real selves -- more estranged than their family roles required them to be -- and so it is no accident that they arrive at graduation with a cool (or contrived warm) bedside manner.

What alternative is available for nurses to take the place of a bedside manner which seems to defeat many of the aims of the nursing profession? How can nurses with a confirmed bedside manner get rid of it, and how can students be trained so that they will not have chronic need to hide their real selves behind a professional mask? Observation has shown that experienced nurses who have been fortunate enough, following a "nervous breakdown," to undergo intensive psychotherapy, will abandon their prior rigid interpersonal patterns with patients, displaying greater insight into themselves and greater empathy with their patients. They feel and act more freely with their patients and elicit more self-disclosure from patients. This would imply that all nurses should undergo intensive psychotherapy. In fact, this is impracticable, and it is not certain that it would accomplish its aim. There is growing evidence to show, however, that the average nurse can increase her ability both to promote self-disclosure in patients and to utilize the disclosures as guides for more personalized, "tailor-made" nursing actions. The most direct and simple step which she can take in this direction is to make use of all available time, whether it be 10 seconds or half an hour, to permit the patient to talk about what is on his mind. This does not mean formal interviewing. Rather, it implies simply taking steps to become acquainted with this very person to whom one is giving an injection or backrub. It will come as a surprise to many nurses when they discover the extent to which they have actually avoided many opportunities to listen to a patient who was bursting to reveal what was on his mind.

The question of training nurses in the direction of greater real-self being is another matter altogether. It seems to call for a radical alteration in their instructor's conception of what nursing education entails. Much learning about what it means to be a nurse occurs informally when students identify with the attitudes and practices displayed by her teachers. If these teachers are impersonal and have an air of perfection and imperturbability about them, the students are likely to pursue this impossible pinnacle of human performance. If the teacher has a "classroom manner" similar to her bedside manner then it is difficult to see how the student can ever come to care about her own real self, much less the real self of her patients. One evaluates his real self in the manner that significant others evaluate it. If one's teachers are impersonal in their transactions to students, likely the students will be impersonal in their attitude toward themselves. If one's teachers no longer practice active personalized nursing care, but only preach about it, the students likely acquire the concept that teaching's the thing and nursing care is for flunkies. As the teachers are, so will the students become, with the exception of those rebellious students who become their teachers in reverse.

We are beginning to discover that basically normal people can become sensitized and more alert to their own real selves, as well as the real-self expressions of others, without recourse to intensive psychotherapy or technical books on psychodynamics. In fact, the two kinds of alertness seem to grow together. Possibly then, if all nurses who are in an instructional role become less afraid to disclose themselves to their students and proceed to do so, the students will acquire more realistic and feasible role-models with which to identify. If teachers will show a greater interest in knowing the real selves of the students whom they teach, they will doubtless foster greater acknowledgment of their real selves by the students. An interest in and acknowledgment of the full gamut of inner experience in oneself and in others is contagious — just as contagious as is impersonality and indifference to inner experience. It may be proposed as a testable hypothesis that if nursing faculty in colleges and schools become more capable of acknowledging their own inner experience apropos their subject matter and patient contacts, disclosing this to students; and if the faculty acknowledge the feelings of their students, granting them the freedom to have all kinds of feelings; and if the faculty actually practice both nursing and teaching of students on the basis of this greater insight and empathy — then students will learn (or not unlearn) how to be themselves with patients. Doubtless, a regime of this sort would abolish the contrived, tense, even frantic, and sometimes silly specimen of behavior that we have called the bedside manner.

Interviewing Techniques in Probation and Parole

Henry L. Hartman, M.D., Psychiatrist

The Initial Interview (Part 1)*

The previous two articles in this series on interviewing techniques were concerned with building the sort of relationship between the probation officer and the probationer which made communication possible, and with the art of listening to what is actually being communicated during the interview. This article and the one to follow will deal with the techniques employed in carrying on the initial interview. In practice the initial interview may extend over two or three sessions with the probationer.[1] It has two main goals: (1) developing a relationship and (2) obtaining a picture of the probationer and his developmental background from which the probation officer can draw some inferences as to the dynamics of the probationer's anti-social behavior.

The subjects to be discussed in this article will relate to techniques of commencing the interview and keeping the flow of communication alive and, just as importantly, focusing and structuring it. The final article in this series will discuss the techniques to be utilized in continuing and terminating the interview. As in the previous two papers, an attempt will be made to be as concrete and specific as possible. In reading these suggestions, however, the probation officer must be mindful of the fact that in this or any other type of interviewing, two variables are always present. In this situation these are the personality of the probationer and the personality of the probation officer. Hence, the suggestions made will not always be applicable to every probationer, nor will every probation officer find that his personality allows him to feel comfortable while using all of these techniques. Where it is feasible, an attempt will be made to differentiate the type of person with whom one technique or another should be utilized. This is, however, not always within the scope of an essay of this length. As far as the individual probation officer is concerned it will be up to his own judgment as to which suggestions he feels can best be utilized within the framework of his own personality.

Beginning the Interview

The first time the officer sees the probationer it is necessary for him to introduce himself and his function. This introduction should always, in one way or another, convey the idea of wanting to be of help. This idea must be conveyed without any air of condescension, and without appearing to be either superior or punitive. Some such statement as, "I'm John Jones. I'm going to be your probation officer. The court has assigned me to help you while you are on probation. We'll be talking together about you from time to time," will serve the purpose. Once this sort of preparatory introduction has been made the officer should turn his attention immediately to the matters of building a relationship and listening to the probationer, techniques for which were discussed in the first two articles of this series.

It might seem that the most important thing to do immediately is to put the probationer at ease, and it is quite a temptation when interviewing a person for the first time, particularly if he seems tense and ill at ease, to start with small talk or anything that might ease the strain of meeting. Talk about the weather, sports, school, work, might serve that purpose, but it is extremely difficult for the officer to respond in such a way as to convey a feeling of being nonjudgmental or understanding when he is responding to the probationer's answer to "It's a beautiful day, isn't it?" or for the officer to empathize with the probationer who has replied to, "I see the Packers won again last Saturday." Possibly this may convey to the probationer that the probation officer is unhurried and has plenty of time to spend *with* him, but it does not convey interest or the feeling that the officer has plenty of time to spend on his problems.

This sort of thing then should be avoided if possible. At times it may be an effective technique in allaying the officer's own anxiety. If the officer does feel a need for small talk to bridge the gap, and many may, then it should be focused on the probationer. Thus, if talking about the weather, instead of saying "Isn't it a warm day?" it might be phrased, "Does this

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*This is the third of a series of four articles on interviewing in probation and parole by Dr. Henry L. Hartman, a practicing psyciatrist at Toledo, Ohio, and consultant to the Child Study Institute of Toledo's Family Court Center. Dr. Hartman's third article is the first of a series of two on the initial interview. The concluding article will appear in the December issue of Federal Probation.

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hot weather bother you?" Or one might say "Do you get down on grey days like this" or, if about sports, "Which team do you like in the series?" In other words the focus should be on the probationer and his reactions from the very beginning, regardless of the topic under discussion. When feasible though, the small talk should be omitted.

Right from the beginning the probationer should be the topic of the conversation. In general this focus on the probationer should be in as broad and nonspecific terms as possible. Once the introduction is out of the way it seems preferable in this initial interview to start with the current situation. The opening gambit should always be one which allows a multiplicity of answers, rather than requiring one specific response. Thus, "Would you like to tell me about it?" or "You seem to be having difficulties, would you like to talk about them?" or "Would you like to talk about what brought you here?" are all acceptable opening questions. Note that these contrast sharply with "tell me what you did?" or "Why did you do it?" or "How did you ever get mixed up in something like this?" The reason for this insistence on the broad approach is that it gives the individual a chance to talk about what is really on his mind, even though it may not be at all what the officer expects, and hence furnishes a valuable lead to what some of the real factors in the situation may be.

Two cases will serve to illustrate the sort of answer which may be expected from this type of approach. A 12-year-old boy is seen following his arrest for shoplifting. This, it was learned, was the latest in a series of offenses dating back for some time, starting with pilfering pennies from his mother's purse, going on to fighting in an unprovoked manner, stealing from other youngsters, stealing from the teacher's purse, and finally culminating in the shoplifting, in which there was not too much attempt at concealment apparent. When asked to "tell me about it," he replied, "Well, the way I see it is that somebody's got to say no to me and make it stick." As he talked on it became apparent that he saw himself as the prize in a struggle between his parents, as to which one could do the most for him, cover up most for him from the other and from the authorities. If one said that he could not do something, it was easy to get permission from the other. If both said no, no punishment would follow anyway, or if one threatened punishment the other would protect him from it. He was literally afraid of what he might be tempted to do if controls were not applied, and each offense was a way of asking for them. All of this, with the exception of the last statement about controls which was implied rather than overt, came out spontaneously in response to, "Would you like to tell me about it?"

The second example involves a mother being interviewed in connection with severely delinquent behavior on the part of a 16-year-old son. She is not asked "Would you like to tell me about your son?" but again the question is phrased, "Would you like to tell me about it?" Once again the answer leads almost immediately to the heart of the difficulty. "I just can't understand that man," and it becomes quickly apparent that she is talking not about the son, but about the husband. Very quickly a picture emerges of him as a severely paranoid individual, who in his illness has dominated the family in such an unreasonable fashion that the son's behavior can be understood as a method of coping with this irrational tyranny.

One immediate advantage of this nondirective type of approach can be seen from the foregoing examples. Not infrequently the initial question may lead directly to the root of the problem with which the officer will have to deal. There is another more subtle and more far-reaching implication of this approach, the benefits of which are not so immediately apparent, but which may be of even greater significance as the relationship between the probationer and his officer continues. Right at the beginning of this relationship it is made clear by this approach that this is not a situation in which the officer is going to do something to or for the probationer, but rather that this is to be a situation in which they do something together, and that the role of the probationer is equally as important as the role of the officer for a successful conclusion of their mutual task.

If at the beginning of the interview the probationer is able to respond to some such nondirective question as "tell me about it," then the interview is off to a good start. The concluding article will discuss the conduct of the interview from this point. It would be very fortunate if all initial interviews followed this pattern, but unfortunately this is not always true. Not uncommonly the probationer has some difficulty in responding to this sort of nondirective question. Where this difficulty is manifested by silence it is probably wiser at this point, early in the relationship, not to let the silence be prolonged very long. A prolonged silence at this time is likely to build too much tension of an unwanted sort. At a later stage in working with the probationer, at times even at a later stage in the initial interview, tension building by means of silence may be a helpful thing. Such tension helps to mobilize anxiety, and the probationer may then begin to talk about the things he is most anxious about.

At this moment of initiating the first interview, however, such tension is likely to be destructive rather than constructive, and so the silence should be broken fairly quickly. A remark may be made such as, "Well, probably you'll want to tell me about it when we get to know each other better," and the conversation shifted to a discussion of neutral topics. The use of the term "neutral topics" does not imply small talk, but rather topics which have reference to the probationer, yet are probably free from any great emotional overtone. There is, of course, always the possibility that a theoretically neutral topic may have emotional overtones for any specific individual. "Is your father alive?" for example, may be quite emotionally laden to a person who feels he is illegitimate, but this can rarely be foreseen. Should it be noted that there is a marked emotional response to what is expected to be a neutral topic, this information is filed away for exploration at a later time.

Frequently the probationer, rather than meeting the question with silence, will respond to "Would you like to tell me about it?" with a question of his own, such as, "About what?" or "What would you like me to tell you about?" This sort of reply is best responded to again as nonspecifically as possible. Some such response as, "Tell me a little about yourself," would be an appropriate rejoinder. If the response to this is something like "What do you want to know about me?" it becomes obvious that a contest is going on, and this should not be allowed to develop. A tentative "Anything that you want to tell me?" should be offered, but at the least sign of hesitation in producing an answer this should be followed immediately with more concrete questions. These may deal with age, education, occupation, hobbies, interests, anything which will furnish the probationer a stimulus to which he may respond without having to reveal too much of himself at this point when he is still unsure of whether he is willing to do so. Where it is at all feasible, even these concrete questions should be phrased in as non-specific a way as possible, in order to leave the door open to an answer to more than just the question asked. For example: "Tell me about your family," rather than "Who's in your family?" "Tell me about your neighborhood," rather than "Where do you live?" "What about school?" instead of "What school do you go to?" These are examples of questions about specific topics, posed in a quite nonspecific way. As noted, this leaves an opening for the probationer to go on and divulge any amount of significant material in the areas under question. It facilitates the flow of communication, and yet gives a little more structure than the previously used, "Would you like to tell me about it?"

Quite commonly just this small amount of stimulus will serve to initiate an exploration of a meaningful and problem-laden area. However, there will be left a relatively small number of individuals who are unable to respond to either of the two suggested approaches, and who will give only specific answers to specific questions asked them. This may be so for any one of a number of reasons. These may be introverted or at times severely inhibited individuals who have a great deal of difficulty in expressing themselves. They may be extremely literal minded people, accustomed to thinking only in the most concrete and specific terms. Or this may be a purely defensive reaction, arising out of a fear of revealing too much. Whatever the reason, these people must be dealt with on their own terms and a simple question-and-answer routine followed for some time until it is possible to build a relationship which can be used to facilitate the communication of problems and feelings.

Focusing the interview

With these last discussed individuals there is no problem in focusing the interview. Each specific question asked serves as the only focus, and the problem is one of stimulating enough spontaneity to allow the officer to identify the important trends in the genesis of the probationer's problems. Focusing also presents no problem in those persons who respond to the nonspecific question asked, exhaust the area, and then wait only for another stimulus to explore a different field as thoroughly. It then becomes only a question of what fields the officer wishes to explore, or to what depth he wishes to go in any field.

Focusing in the initial interview becomes a problem only with those probationers who respond to the invitation to "Tell me about it" with a seemingly endless stream of apparently disconnected material. In such instances the first thing which must be determined is: Will this stream of talk spontaneously answer many of the questions which would ultimately be posed? If the answer to the question is yes, then there is no need to attempt to focus strenuously in the initial interview. Instead the officer may busy himself with sorting and classifying the meaningful material, assessing its significance to the probationer, noting areas which need elaboration and clarification in later interviews, and sorting out the feelings which underlie this recital. Indeed, instead of attempting to focus, the officer, with this sort of person, utilizes those techniques previously described to express interest and facilitate the flow of thought. He nods, smiles, says "mmh-hmmh," repeats the probationer's last words at a pause, empathizes with his feelings, or rephrases a point to emphasize its meaning.

After this initial outpouring it is wise to attempt to focus on only one or two meaningful trends in any one subsequent interview. For example, during the first interview the probationer may have referred to or touched on his feelings of being a failure, his reactions to his criminal offense, his dissatisfaction with his wife, his feelings about what he considered the unreasonable attitudes of his parents when he was growing up, the undisciplined attitudes of his son, the seemingly inordinate demands of his employer, his fantasies of being a big shot, the high cost of living, the success of an older brother, his love for his daughter, etc.

At the subsequent interview the officer should attempt to focus the probationer's responses on one or two topics which seem to be of real significance. Thus, if the probationer again makes some reference to his parents' attitudes, the officer might make some such statement as, "You mentioned something about that last time. Would you like to talk a little about what you felt they really expected of you?" At appropriate moments in the response the question may then be interpolated, "And how did that make you feel?" If the probationer tends to drift from this area of the parents' expectations before it is fully explored, the new topic is acknowledged, but then the discussion is brought back to the parents and their attitudes by means of a pointed question such as, "What was their reaction when you brought home your report card?" If this elicits a feeling of having failed, and an underlying feeling of resentment that it was not really failure, but that the parents' demands were too great, it is not then too difficult to phrase questions or responses in such a way that the connection between the childhood feelings and the present feelings of being a failure become quite clear, and this area can then be explored.

One important point should be stressed here. If a probationer is eager to talk about one topic, the officer should not try to switch him to another, no matter how trivial the former or how significant the latter appear to the officer. Such an attempt can only hinder the formation of a relationship, lead to a lessened feeling of self-worth on the part of the probationer, and increase resistance. Most importantly, what appears to be trivial to the officer may be the preliminary to something which is extremely significant, and which may not emerge if the probationer is not allowed to talk around it at his pace.

If, however, in this initial interview, should there seem to be no real pattern of significance to the individual's flow of words, then the officer should ask himself the question: Is this apparent rambling really representative of this person's normal thought pattern? If the answer seems to be yes, then it becomes obvious that a good deal of time will be wasted in letting him ramble. A definite attempt will have to be made to focus this outpouring. This could be done quite easily, of course, by simply interrupting at any time and asking a pointed question. When the rambling begins again there is another interruption and another question, and so on. Although this will certainly serve to elicit a larger amount of factual information within a given period of time, it is generally wiser to avoid this type of focusing. Instead, it seems preferable to use a technique which might be labeled nondirective focusing. In essence this consists in the use of the reverse of the maneuvers which were previously suggested to convey interest. As the rambling proceeds the officer instead of appearing interested, appears bored. He may yawn, close his eyes, tap with his pencil, drum with his fingers on the chair arm. Instead of saying yes or "mmh-hmmh" he remains silent, unnodding, unresponsive. At first this may seem to have little effect, but before very long the meandering torrent of words slows to a trickle, and then comes to a dead stop. When this silence occurs the officer then proffers a cue about a topic which interests him, and as long as this topic is discussed continues to convey his interest. Once again as the probationer meanders from the topic this same treatment is repeated, and so on, until before very long only topics of interest are being discussed. Obviously this is more time consuming than interrupting and asking questions.

What then are the advantages of this method? First, it keeps the interview from developing into a question and answer session, in which all the necessary facts may be obtained but none of the important feelings.

Second, this expression of disinterest, this method of using boredom, silence, etc., serves as a counterpoint to the show of interest in significant material, so that it underlines this interest when it is present, and helps the probationer to learn relatively quickly about the areas in which the officer is interested. It serves to delineate the areas of significance, keep attention focused on these areas, and allows the probationer to assume the responsibility for working on them.

Third, it does this in a way which does not mobilize his defenses, which does not make him feel dominated and pushed around, as direct questions may. He may not be completely aware of what is going on, and yet he realizes that the probation officer is basically interested in those things which are significant and important to him. The result is that the officer is able to learn about the probationer in a way which allows the latter to retain his self-respect, and without giving him the feeling of having things dragged out from him against his wishes.

At times the answer to "Would you like to tell me about it?" may be not only rambling and seemingly incessant, but also disconnected and disjointed. Under these circumstances there is most probably an underlying mental disorder and medical help should be requested. There is one other possibility which must be considered in attempting to focus a rambling, interminable, seemingly inconsequential answer to the introductory question. The final question which the probation office must consider is: Is this a form of defense — a smoke screen of words, thrown up consciously or unconsciously to avoid talking of anything of significance? If the answer to this question is yes, the method of dealing with it in order to focus the interview will depend on the officer's judgment as to whether it is conscious or unconscious. If it is unconscious, then in all probability it stems from uneasiness in the situation, a fear of the officer as an unknown quantity, and an attempt to gain time in order to size up the situation. Under these circumstances the individual's feelings should be respected and no direct attempt should be made to circumvent this. Instead, the officer, by means of the techniques described in the first article in this series, should direct his efforts toward establishing a relationship, building a feeling of confidence in the probationer, and conveying the feeling that the officer understands and empathizes with the feelings underlying this behavior. With such an individual it may take several interviews before the proper atmosphere can be established to make meaningful interviewing possible.

On the contrary, when this smoke screen is felt to be consciously motivated, particularly if it seems to stem from an attidue of "You can't con me. I'm smarter than you are, Mac," then the officer should intervene directly. In whatever words he chooses to use, most appropriately in the probationer's own vocabulary, the message should be conveyed to "cut out the malarkey and get down to business." Working with such an individual in any sort of meaningful relationship is impossible unless he realizes that the officer is as smart as he, is not going to be fooled, and will not allow himself to be outmaneuvered.

Organizing the interview

The fact that he is using nondirective techniques does not absolve the officer from the responsibility of structuring the interview. The one exception to this occurs when the probationer himself is effectively structuring the interview along constructive lines. While this should occur with more and more frequency as probation continues, it is not too common during early interviews. Since one purpose of the initial interview is to obtain a history, a general picture of the individual and his development, then the structuring should take place along lines which make this possible. In order to do this most effectively the probation officer should have firmly fixed in his mind an outline of the material which he wishes to explore with the probationer during the initial interview. It is not within the scope of this paper to furnish a detailed outline for the officer's use. In general the following topics are expected to be explored:

The parents and parent substitutes: their relationship to each other, relationship to the individual, both during his formative years and at present, with particular emphasis on the standards, values, and methods of discipline, the emotional interactions between them.

The environment: past and present, sociocultural-economic, physical, and emotional.

The individual's development: birth, physical development, health, history, emotional development, school and work adjustment and achievement, hobbies and activities, goals and standards.

The individual's relationships: to parents, siblings, peers, mate, children, authority figures.

Antisocial behavior: past, present attitudes toward it.

The exact details of the outline are not important. What is significant is the use of the outline as a guide to areas to be explored for understanding the probationer and his behavior. Thus, with each topic under discussion the officer should be asking himself two questions: "Has this topic been completely covered?" and "What bearing has this had on the problem which this person is experiencing?" Used in this way the outline serves as a guide to structure the interview and does not become some sort of compartmented box, meant to be neatly filled with assorted facts, each one tucked neatly into place.

Viewed with this attitude the question of whether to follow the outline in order, step by step, does not arise in the interview. Most commonly the area to be covered first will be determined by the probationer's response to the first nonspecific gambit. The importance of the outline in structuring lies in delineating the areas to be explored, and in furnishing a handy mental check list for covering each area thoroughly before moving on to another one.

As was noted in the first article in this series, this does not imply that if a probationer starts to stray from the area under discussion one does not let him do so, but as soon as this side excursion has come to its logical conclusion, the probationer should be led back to that area which was under exploration until each item in that area has been covered. Under no circumstances should zealous desire to satisfy the demands of an outline be allowed to hinder the flow of thought of a probationer who is bursting to talk about a specific topic or problem, no matter if nothing in the outline seems to fit that topic.

In summary

The initial interview, which may in practice last over several sessions, has two functions which must be operative simultaneously. These are to obtain the information about the probationer necessary to delineate the nature and development of his problems, and at the same time to establish the type of relationship which will set the pattern for future meetings between the probationer and the officer. A nondirective approach seems to offer the best way of filling both of these requirements at the same time. By focusing on the probationer and his problems immediately the officer establishes the pattern that these things are important to him. By offering the probationer the opportunity to discuss his problems in a relatively unstructured fashion, the attitude is conveyed that the probationer has an equally important responsibility for working toward a solution as does the officer.

There are several possible ways in which the probationer may respond to a nondirective approach. If he is able to respond significantly immediately there is no problem in managing the interview. He may, however, respond to this approach with silence. Under these circumstances more concrete questions must be asked, but even these should be phrased in a fashion to permit many possible answers.

With either of these responses on the part of the probationer no need arises for the officer to focus the interview. When, however, the probationer responds with a rambling type of soliloquy which contains little of significance, it is then the responsibility of the officer to provide some focus to this flow of words. The way this is done depends to a large measure on the officer's estimate of the underlying cause. If this seems to be the habitual way in which this particular probationer responds to those in his environment, focusing is carried out in a nondirective fashion. If it seems to be the result of fear in the situation, then the underlying fear is dealt with, and the emphasis is placed on the relationship. If, however, it appears to be a definite attempt to obscure and outmaneuver, then it must be attacked directly.

In addition to focusing the flow of thought it is the responsibility of the officer to structure the interview. To do this effectively it is wise for the officer to utilize the framework of an outline which has been thoroughly learned. Care must be taken not to use the outline in a rigid fashion which might tend to constrict the material elicited. Rather it should be used as a guide to a thorough exploration of those areas which are to be covered. How this is done, and the way in which the officer can move easily from one area to another as the interview progresses will be discussed in the concluding article of this series.

> Of course the most important step in the investigation process is that first interview with the defendant, and if you handle it skillfully you not only have the basis for a truly competent report, but you also have gone a long way toward launching the treatment job that must develop later.
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> — Paul W. Keve in *The Probation Officer Investigates* (1960)

The Initial Interview (Part 2)*

The first of the two articles in this series on interviewing techniques explored, among other things, various methods of commencing the initial interview. In that article it was suggested that a nondirective technique could be quite helpful in allowing the person being interviewed to express his feelings about his basic problems spontaneously and naturally. Methods of dealing with persons who are unable to respond immediately to this type of approach were also indicated, as were techniques for dealing with those who, for one reason or other, tend to ramble in a desultory and time-wasting fashion.

This article attempts to pursue in some detail the further conduct of the initial interview beyond its opening stages. These opening stages tend to fall into two general patterns. The first pattern is seen when interviewing those who are able to respond immediately to a nondirective approach; the second, with those who initially require a directive question-and-answer technique.

Letting the probationer pursue his response

With the individual who is able to respond immediately to the probation officer's, "Would you like to tell me about it," the officer lets him pursue the response until he has talked himself out. It is generally wisest not to push for elaboration of specific details about this topic, either when the probationer is talking or when he runs down, but simply to make appropriate remarks as he talks, remarks which indicate the officer's understanding and interest in what is being said.

The reason for not pressing for amplification at that time is that not enough is known about the individual to evaluate his willingness or ability to expand on what he has said. When the topic has been exhausted then some sort of summarizing remark should be made which will serve as a transition to covering topics in the social history or presentence investigation. A typical remark might be, "Well that seems to give us a good picture of the way you feel about it, suppose we find out a little about the background and possibly that will help us to understand why you might have these feelings. Suppose we try to learn a little more about it." It is then easy to proceed to, "Tell me a little about your family," or "your job" or any of the other topics which should be explored.

In those people who originally seem to respond well to this nondirective approach, the handling of this stage of the interview, this first out-pouring in response to the opening gambit, is frequently crucial in determining the success or failure of the entire interview. It is here that the need to be interested, understanding, and above all, nonjudgmental is so important. At this moment the officer knows nothing of the probationer and his needs, and the latter knows nothing of the officer and his attitudes.

Officer is tested to see how he responds

The first statements the individual makes often are tests to see how the officer will respond. The following is a good example of how this testing may be carried on. This is a man who was interviewed with no prior knowledge of his situation. His appointment had been made through his attorney by the secretary, and no information, not even the nature of the offense with which he was charged, had been furnished. His response to, "Would you like to tell me about it?" was, "Well, you see, I have quite a problem. I'm one of those guys, if he's been without a woman for some time and he gets a few drinks, then he always wants to go looking for guys who like other guys."

The tone of voice with which these remarks were made, and the searching facial expression accompanying them indicated an expectation and a fear that the response would be couched in some judgmental fashion. This was obviously a test of whether he could be accepted and find some understanding. At this point it would be too risky to attempt to convey understanding, since obviously not enough was known about him to be able to understand. The response then was couched in terms which would indicate acceptance of his behavior, and the desire to understand it.

"How does that make you feel?" His answer was on the surface, a matter of fact statement, "It makes me feel like hell," but the tone of voice and the quizzical facial expression turned this statement into a question. He was really saying, "You must think I'm pretty terrible, awful, way out, can't be helped, don't you?" Any attempt to empathize with the surface statement with some such remark as, "An urge like that sure must shake you" or "I can imagine that you do feel like hell" would only serve to confirm the suspicions implicit in the tone of voice and facial expression. Again, this was a way of testing. The answer given was, "That must be an uncomfortable way to feel. Suppose you tell me a little more about it." Since this contained no judgment that he was good, bad, abnormal or depraved, but did indicate interest to know more about him, he was able to relax, let down his guard, and, at least for that time, stop testing. At this stage of the interview, the officer must then phrase his responses very carefully and should try to be aware of the various ways in which he may be tested.

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*This is the final presentation of a series of four articles on interviewing in probation and parole by Dr. Henry L. Hartman, a practicing psychiatrist at Toledo, Ohio, and consultant to the Child Study Institute of Toledo's Family Court Center.

Probationers respond differently

With the sort of person who responds freely to, "Would you like to tell me about it?" there is generally the same sort of response to "Tell me about your parents," "work," "wife," or any other topic which is introduced and suggestions will be made later as to how to proceed. With the individual who responds only to specific questions, and then only in a specific and concrete fashion without any verbal expression of feelings and attitudes it becomes a task to convert this sort of response into one which will be more meaningful and through which a relationship can be established. In dealing with this kind of person it is crucial that the officer remain on the alert for the first answer which contains material over and above the question asked. If the officer has been alert, and has responded with the proper degree of interest, and particularly with no implication of passing judgment when this has happened, then a significant milestone will have been passed.

Once this first tentative ball has been tossed to the officer and has been expertly fielded and thrown back, then the defenses come down faster and faster. For example, such a question-and-answer interview with only bare answers to the questions may have been going on and the question is asked, "What is your wife's attitude toward your drinking?" and the answer comes back, "She doesn't like it. She bawls the hell out of me. Then I go out and take another drink."

Here for the first time the person has expanded on the question asked of him. He has volunteered his reaction. It might be quite tempting to point out at this opening that this is exactly the wrong thing to do, that "It gets you nowhere" or "That just makes the situation worse" or some other remark which points out the inadequacy of this reaction. This is just the sort of response that the probationer is expecting, anticipating that here, too, in the person of the probation officer, is another individual who will pass judgment on him and find him wanting. This temptation then must be resisted. Instead, some way should be found to convey acceptance and understanding. "It kind of gripes you when she jumps you," or "You wish she'd keep her mouth shut," might be appropriate remarks. Once this first test has been properly passed, the individual will almost always open up more and more.

At times this first test, or a subsequent one, may be even more direct and more pointed. For instance, in the example just used, the individual may add to his, "Then I go out and get another drink", the direct question, "What would you do?" This sort of loaded question puts the officer directly on the spot. Any direct answer he gives will be wrong. If he replies "I guess I'd do the same thing" he is condoning the behavior and may jeopardize his future effectiveness in working with this man to change his behavioral patterns. If the officer at this time, before a relationship has been established, advances a more effective way of dealing with the situation, it may well be interpreted as criticism and judgment, and establishment of a relationship is hindered. If the officer intimates that such a situation could not happen to him, he is being "holier than thou" and no relationship can flourish in such an atmosphere.

The most likely solution for this dilemma is to evade the question and attempt to focus on the underlying feelings. The answer then might be phrased in some such terms as "I don't know quite what I'd do. I suppose it would depend on how I felt. Does it kind of gripe you when she chews you out?" Almost always this sort of response will convey acceptance and understanding without compromising the officer's position.

Importance of voluntarily introduced topics

In addition to being alert to the first spontaneous verbalization on the part of this sort of individual the officer should also be equally attuned to the first voluntary introduction of a new topic, at the initiative of the person being interviewed. This is equally true whether the individual has been responding well or poorly to a nondirective approach. What does the introduction of this new topic mean to this person? Is there an association between it and the topic which had just been under discussion? Is this association an obvious one, or one which is obscure, and at the meaning of which the officer can only guess? Is it a sign that the probationer is now more at ease and secure, and hence can talk of things of more meaning and urgency to him? Is this subject that he is bringing up so pressing to him that he must introduce it, even though it seems inappropriate? Is it possible, on the contrary, that the subject previously under discussion is so threatening that it becomes essential to get away from it, and this new topic is just a red herring, designed to divert the officer from something about which the probationer cannot yet talk? If, while the officer is answering these questions in his own mind, he demonstrates his interest and understanding in the probationer, and has not passed any judgments, the latter will continue to relax and the interview will proceed more and more easily.

Once this relaxation has taken place, the general form of the interview will become identical in either instance. The pace at which this proceeds, the material covered, the depth to which it is explored, will be determined by what the officer has learned of the individual during these early stages. As this early stage has been going on, the officer, by utilizing those various aspects of listening discussed in the second article of this series[1] and evaluating the information obtained from them, will have formed a rough, but it is to be hoped reasonably accurate picture of the individual and his needs, particularly as those needs relate to the interview situation. The supposition is that the officer can utilize his knowledge of those needs to facilitate the interview.

While this sort of scrutiny must be most intense during the early phases of the interview the officer should continue to be alert to modify his impressions if necessary as the interview progresses. Thus the officer notes how noncommital or how descriptive are the answers to his questions, whether the probationer is only following the officer's lead or whether he branches off on associative patterns of his own. The officer observes whether the probationer is watching intently to see what effect his responses have on the officer, and whether these responses are modified in terms of what the probationer believes the officer's reaction to them to be. Does he converse spontaneously or does he always have to be prodded?

It is from observations of this nature in these early stages of the interview that the officer begins to determine how the needs of the probationer may be met most satisfactorily. Is this a passive, rather dependent sort of person who is going to require a great deal of help in the interview situation, or is he an aggressive, independent person, who, once reasonably at ease, will relate much better if left largely to his own devices? Is he continuously wary and on guard so that questions will have to be carefully phrased so as not to evoke suspicion? Is there a great deal of hostility that will have to be overcome before he gets really involved? Is there a great deal of loquacious, rambling, verbal production for which the focusing techniques outlined in the previous article[2] will have to be utilized? It is with the answers to this type of question in mind that the officer proceeds with eliciting the background material.

Cues for direction and timing

While this background material is being obtained the officer should be on the watch for two other signs which will serve as cues for direction and timing. Both of these have to do with tension on the part of the probationer. Almost all individuals, particularly in the initial interview, are likely to be tense to a greater or lesser degree during the early stages of the interview situation. It is important not to attempt to pursue material which appears to be emotionally laden to the individual until the signs of this tension have begun to lessen. Indeed, no matter how great the pressure of time upon the officer, it is wiser, where indicated, to postpone a discussion of significant material for as many sessions as may be necessary until the probationer seems to trust him and is able to be at ease. This feeling of being at ease may be assayed in many ways.

On the physical side there is an obvious settling down. There is no longer foot tapping or nail biting or hand motion. The individual becomes quieter and more composed. A stiff posture is replaced by a relaxed status. Clenched hands loosen. Lines in the forehead or between the eyebrows smooth out. The speech becomes less jerky or bitten. Formal, precise speech is replaced by more easy-going colloquial speech, and there are fewer and fewer big words and carefully constructed sentences. At times the reverse is true and there is less and less profanity as relaxation takes place. Hostile attitudes soften, truculent attitudes disappear, and there is more and more spontaneous verbalization.

Just as signs of relaxation of tension are indicators of the proper time for discussion of emotionally laden material, so, too, may evidences of increased tension be indicative of what material is emotionally significant to the individual. While the various background topics referred to in the suggested outline in the previous article are being explored, the officer takes note of what subjects seem to call forth manifestations of increased tension, blocks, hesitation, bodily manifestations of emotional response, forced change of subject, etc. Only as the individual begins to relax, and only when enough has been learned about him, so that the officer feels he has some sort of understanding of the basic personality mechanisms, defenses, and needs involved, should an attempt be made to explore these significant areas. Generally these areas will be found to revolve around relationships to other significant people. At times they will be seen in relationship to the offense itself. Not uncommonly they may involve drives or impulses (frequently of a sexual nature) which the individual finds unacceptable. Whatever their nature it is useless to attempt to explore them until the individual is ready to discuss them, as exemplified by his being at ease and showing signs of a beginning relationship with the officer.

Exploration of sensitive areas

When one does begin to explore these sensitive areas it is probably better to start with an indirect approach. For example if the area involves the relationship with another person, a parent, spouse, employer, friend, the original focus should be on the behavior and feelings of the other person. If the questions are phrased in a general way it is possible to get a picture, not only of how the person being interviewed sees the other, but also of how the probationer views himself, and his own adequacies and inadequacies in handling the particular attitudes and patterns that he has been describing. Here, too, the officer may utilize most effectively the techniques of conveying interest and empathy to facilitate the flow of thought.

At this stage in the interview if silences begin occurring they should be broken not by a question or change of topic, but first by a repetition of the last two or three words that the individual has said as he has come to a pause, or by a restatement of the feelings expressed, or a brief summary of what has been said, or by "that must have made you feel" in such or such a way. It is as these emotionally significant areas are being discussed that the officer can really begin to develop a lasting and effective relationship, because he can now empathize most safely with the probationer. Not only is the material under discusssion more open to empathy-laden responses, but the officer begins to know enough about the probationer so that he can offer these responses with reasonable assurance that they correctly interpret the underlying feelings. If the interview is progressing satisfactorily at this point it should be necessary to furnish only a cue or two as to what the officer is interested in to have the individual respond freely.

There is one exception to this general rule of not touching on sensitive areas until the officer feels that the probationer is ready. This exception occurs when the individual introduces the area himself. It was noted earlier that when this occurs during the opening stages of the interview no attempt is made to push the topic farther than the individual is willing to go spontaneously. If, however, the probationer introduces important areas spontaneously at a later stage of the interview they should be explored to the fullest no matter how upset or how embarrassed he appears to be. The very fact that he brought this topic up means that he is eager to talk about it, even though it may be extremely difficult for him. This does not imply that under these circumstances the probationer should be hounded with questions. It does imply that he should be encouraged by all the methods outlined in this series of articles or, at times, an encouraging "Yes, yes, go on" may be used.

At times it may be helpful to verbalize something like "I'm sure that this must be hard for you to talk about, but obviously you feel that you'll feel better if you do get it out. Won't you please continue?" Or if this person has been observed to have low feelings of self-esteem it may be of help to say something like, "I admire your wanting to talk about something as upsetting as this." Whatever the technique, once the probationer gets into such an area himself he must be kept on it.

Once such an area has been opened up, whether by the officer or the probationer, and the discussion is well initiated, it should then be continued by the officer as confidently, matter-of-factly, and specifically as possible. This is because the individual is himself afraid of this subject. And if the officer hesitates or generalizes the individual is likely to interpret this as beating around the bush, and as an indication that the officer is as reluctant and afraid to discuss it as he is. Once the officer has decided the time is ripe to move into this area he should not hesitate.

More than any other areas dealing with the probationer's life, these topics of emotional significance should be explored as completely as possible at the time they are first brought up for discussion. There are two reasons why this thoroughness is necessary. The first is, of course, that it may be of great therapeutic benefit to the probationer to spit it out, to look at it with someone in whom he has confidence in as complete a fashion as possible. The second reason is that once that particular aspect of the individual's feelings and attitudes has been opened and then closed, it may be almost impossible to ever open it again. If it has been thoroughly explored the relief obtained may be sufficient so that it is no longer necessary for the individual to reopen it. If it has not been thoroughly discussed then the individual may well feel that the painful effort of talking about this subject, so significant to him, was wasted and that the officer did not consider it important enough to spend more time on it. Moreover, he may be too embarrassed, resentful, or hurt to want to ever discuss it again.

Attitudes to communicate to the probationer

Throughout this series of articles the emphasis has been on interviewing techniques which would be helpful to the probation or parole officer in understanding the individuals with whom he is working. It was stressed in the first article that the relationship between the officer and the probationer was of prime importance in attaining that understanding. It was also noted that the probation or parole officer had two further goals in his work with the individual, namely to help the individual to understand himself and his behavior, and to use that understanding to help him to modify that behavior. This can only be done if the proper relationship has been established, commencing with the initial interview. It is not within the scope of this paper to embark on an extensive discussion of the means of using the relationship in modifying behavior, but it would seem helpful to abstract from what has been discussed, with some slight expansion, some aspects of this relationship which can be of use in further interviewing situations. Within the relationship there are four attitudes which the officer must communicate to the probationer for the latter to be able to grow along desirable lines. This list has been adapted from Lewis Wolberg's *Technique of Psychotherapy*.

First. The officer must communicate an understanding of the problem. Most individuals want their probation workers to be intelligent, wise, and perspicacious. Means of convincing the probationer of that competence have been discussed. One of these means is the technique of reflecting back to him the feelings and attitudes of the probationer, both those he has verbalized and those he has conveyed in nonverbal ways, the tone of his voice, his facial expressions, his mannerisms. Also of use is the technique of putting into words the unexpressed worries and concerns which the probationer has, and which the officer senses both from the words and attitudes expressed and from his own knowledge of what worries and concerns are common in similar situations. This understanding can also be communicated by displaying sensitivity to the individual's moods and conflicts. It is not necessary for the officer to present himself as infallible, indeed it is a mistake to do so, as this might well damage the individual's own self-esteem, but it is necessary to avoid expressions of confusion. Every effort should be made not to forget important items of information about the probationer, but since no one is infallible, an occasional minor error will not be irretrievable.

One excellent technique for communicating understanding which has not been touched on to this point consists of supplying the proper word when the individual seems to be groping for one. In using this technique the officer must be sure the word he supplies is the one the probationer is groping for. This technique can be acquired by practicing it mentally whenever an individual being interviewed seems to be reaching for a word, and not expressing it verbally until a batting average of nine hundred in supplying the right word has been attained.

Second. Interest is the second attitude which must be communicated in building the relationship to the point where it can be effectively utilized. As was noted previously this means interest in the probationer as a person, not as a laboratory specimen. The officer demonstrates this interest by paying close attention to what the probationer says about his likes and dislikes, his ambitions, his goals. What may seem like a discussion of trivia, hobbies, school subjects, success in sports may, if properly exploited, be an important way of showing interest. This discussion of these subjects as a way of showing interest is not to be used by the officer as a rationalization for failure to get into more important or significant topics, but they have their place.

The technique of communicating an attitude of interest by remembering minor details of what the probationer has previously said has been mentioned earlier but bears repeating. At times it is very helpful for the officer to go out of his way by seeing the probationer at a time or place more suitable or convenient to the latter. This should not be done as a routine as it fosters manipulative and dependent behavior in the client. The reverse of this general principle of building the relationship by a show of interest is equally true. A display of disinterest and inattentiveness is damaging to the relationship.

Third. There should be the communication of tolerance and acceptance. In essence what this implies is the quality of being nonjudgmental. It must again be stressed that being tolerant and accepting does not mean condoning any more than it means condemning. It does mean that the officer recognizes that the probationer has certain drives and desires which he may not want to accept, may not want to respond to, but still does in spite of himself. The probation officer must accept these as part of the reality situation while he is trying to help the individual to come to grips with them.

This attitude of the officer may be conveyed by careful attention to what the probationer says while maintaining a calm and accepting facial expression. It is a truism in this type of interviewing that "mmh hmm" is always acceptable, while "nuh nhh" never is. Along with this there should be an absence of irritability and emotional outbursts on the part of the officer, and a complete lack of expressed or implied reproach.

Fourth. The final, and probably most effective way of cementing the relationship is by communicating empathy. A good deal of time was spent earlier in describing the use of "and that must have made you feel" in communicating empathy. While this is the main technique in the early stages of the relationship it may be supplemented by other means as time goes on. One of these is discussing the more obvious conscious conflicts which bother the probationer, and communicating an appreciation of how upsetting these must be while explaining why they are disturbing.

Another consists in recognizing the probationer's feelings and seeing them from his point of view, being frank and honest with him, and accepting him in spite of his "bad" qualities, whatever he may feel these are. The officer must also express his empathy and warmth, not only by words, but also by gestures, facial expressions, and other nonverbal behavior. Empathy may also be conveyed by giving support and reassurance to the probationer, even at the risk of his becoming dependent on the officer.

Finally the communication of empathy is enhanced by the way the probationer's feelings of hostility are handled, not only the feelings directed against others in the environment, but also those directed against the officer himself. If they can be accepted as an inevitable part of the individual's reaction to his own inner turmoil these feelings become blunted, and the feeling of "he feels with me" is secured.

In conclusion, if the officer is willing to spend the time and effort to put into practice the techniques suggested in this series of articles he will find that interviewing is not only an effective tool for understanding and modifying the probationer's behavior, but also a satisfying, exciting, and rewarding experience in itself.

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CHILD ABUSE AND NEGLECT

Social Services Reader II

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Objective

Social Services Reader II supplements the introductory material presented in Reader I with articles directed to specific training needs that were identified by participants in the first year of the Child Protective Services Training Project.

These articles are intended for direct service workers, supervisors, and others concerned about the growing problem of child abuse and neglect. The emphasis is on daily practice. An introduction presents an overview of current issues and predicts future developments in child protective services.

It is hoped that the articles will provide answers to some of the problems faced by workers today and will stimulate ongoing discussion of the significant issues.

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Introduction

The purposes of this introduction are to share with you the past two years' experience in the training projects in child abuse and neglect, introduce the articles in this year's reader, take a brief look at nationally emerging aspects of abuse and neglect, and present several new points of knowledge that should be readily adaptable to daily practice.

Child Protective Services Training Project

In past years, caseworkers in the training sessions on Child Protective Services and during the needs assessment visits to various counties have continually requested that we share with them and teach them "the latest," i.e., new techniques and ideas on child abuse and child neglect. They, the workers, had heard all that "old stuff before" and unconsciously perhaps were asking for magical solutions to the tough problems which they face daily. Well, common sense tells us that to know where we are going, we must first know where we have been.

The first training sessions provided a mutual learning experience for both the trainers and the workers. An attempt was made to put together a core of pertinent, practice knowledge, attitudes, and values on child abuse and neglect and to present these in teaching and materials development. The Social Services Reader I in Child Abuse and Neglect[1] was an introductory tool, a starting point for new workers in CPS. It did not represent a comprehensive view of child abuse and neglect, but rather a cross-section of the literature available on the subject at that time. Many of the articles were heavily influenced by the "medical model" and presented an intrapsychic view of child abuse and neglect. Many early programs and studies were heavily influenced by C. Henry Kempe's[2] "battered child syndrome," Vincent Fontana's[3] "maltreatment syndrome," Ray Helfer's[4] "W.A.R.-world of abnormal rearing," contributions, made by physicians, which were significant to the field in the 60's and early 70's. The certainty of medical diagnosis and X-ray gave substance to what had long been known to a broad spectrum of professionals involved in protective services but often viewed with disbelief by the general public and many segments of the professional community as well (e.g., legal, medical, academic). The fact is that parents and caretakers do abuse and neglect children at alarming rates in our society today. As these factors were repeatedly brought to society's attention, they led to a general public awareness of the problems of abuse and neglect. The legal, medical, social, and psychological input culminated in new legislation policies. From this emerged mandates in the field of Child Protective Services as we know it today, e.g., all of the 50 states have passed legislation and set up reporting systems.

Other articles in the Social Services Reader I outlined the broad and interrelated parameters of CPS; namely, use of community resources, the caseworker's professional use of self in outreach work, the use of authority in CPS, working with neglectful families, group treatment of abuse and neglect, etc. Articles that presented the social work gestalt of person-problem-situation allowed the reader to view other transactional aspects of the situation.

Social Services Reader II

Professional growth is a process in which bits and pieces of knowledge are added to practice values and skills. Sometimes the pieces are bigger than others. Sometimes they are immediately usable; sometimes they must be discarded or shelved for further needs; sometimes, because of new inputs, the worker must discard routine practices.

The following collection of articles grew out of the learning needs expressed by CPS workers in the first year of the training program and were incorporated and presented to these workers in the second training year. Each is part of the process of adding knowledge, attitudes, and skills to daily practice.

The common concerns heard during training sessions and in our needs assessment that first year were for "something on" treatment, foster care, incest, case management, supervision and law; new ideas, techniques, and theories about child abuse and neglect were also sought.

In this volume, we attempt to meet some of those urgently expressed needs, realizing that each could be a project in itself. The views expressed are for practice and discussion. Each author has approached the subject in his/her own style and with his/her own bias. This leaves the workers (readers) free to choose what is most applicable to them or their specific situations.

The practice points most evident in the Sherman, Wells, Didier and Kilroy articles are those of grief, loss, fixation, and role reversal. These are certainly not new topics in themselves, but are presented here in a form that should be readily utilized in the CPS worker's daily practice experience.

Dr. Sherman's article "Applications of Transactional Analysis to Abuse and Neglect" presents a new view of abusive and neglectful parents and their problems in a multidimensional scheme. Using the short-hand of "TA" constructs, he provides the worker with a new tool to reach CPS clients and to understand the variables of parenting presented in the person-problem-situation before him/her.

Susan Wells' article is a helpful resource in reviewing some of the primary points presented by Kempe and Helfer in working with abusive families. Jane Kilroy's discussion of incest and its destructiveness to families offers the workers a practical analysis of a difficult but common problem which is often overlooked. The subject is presented in a framework often found in local CPS sexual abuse cases and, as such, will be most helpful in daily practice.

Dr. Didier's papers on foster care from the perspectives of worker and child, note a key concept in placement -- the meaning of loss and how the child, foster parents, and worker deal with this. She discusses and summarizes important concepts related to this topic, such as object relationships and the grief process. The reader is given an opportunity of going through the entire process step-by-step with the worker. In the second paper, "What Separation Means to a Foster Child," the idea of loss is discussed further and the adjustment of the child in placement is examined specifically from the child's point of view. The reader is given an opportunity to utilize the concepts of the paper through the adapted exercise at the end. The idea of basic trust is also reviewed.

Dr. Pflanczer's paper is the logical extension of his first paper on community organization and the role of the supervisor as case manager. He notes "supervisory personnel in local agencies may be expected to become competent caseload managers without losing their virtues as case supervisors," underlining the point that supervisory and managerial skills are not antithetical but complementary.

These were some of the pertinent topics covered in the project and the 27-county region it served. Viewing other segments of the society and reviewing the emerging highlights of the field are intended to serve as means of sharing with you the national trends of a complex field which we glibly call "CPS." Our region is just one small part of the picture.

Nationally emerging aspects of abuse and neglect

By 1976 child abuse had become a household word. Federal monies for training, demonstration, research and evaluation projects in child abuse and neglect were available throughout the country; National CAN Centers and clearing houses were established.

As was aptly noted in Child Abuse and Neglect - The Problem and Its Management:

> The Maltreatment of children is a problem of people living together, interacting in complex ways. It involves not only the tens of thousands of families in which children suffer physical, emotional, and psychological maltreatment each year but also the countless people who are attempting to understand and manage the problem: members of federal, state, and local governments; those in the health care, legal, and social system; taxpayers; and anyone concerned about the welfare of children and families.
>
> In families and societies, as in other systems of human interaction, causes and effects are often obscure. Changes introduced at one point reverberate through the system to produce unexpected results in a hundred other places.[5]

The changes and reverberations grew as the child abuse and neglect mandates came into effect -- within the field and within the society. Enters the era of accountability, Title XX, computerization and forms, sizable cutbacks in personnel and services in departments of social services. Elsewhere new treatment techniques and modalities emerged (e.g., Parents Anonymous, CALM, SCAN) as well as new research findings. Still other significant historical and sociological changes took place at alarming rates -- more and younger single-parent and divided families (since 1970 an increase of 1 million!)[6] and the growing realization that slowly a revolution was taking place within the field of child welfare itself, in New York State the "392" reviews, the Child Protection Act, the growing rights of children, and soon several major legal revisions in the field of child welfare as recommended by the Child Welfare Commission of the New York State Legislature.[7]

> The complexity of the problem: Seen from only one perspective at a time, the picture of child abuse and neglect seems relatively simple to understand....
>
> Seen as a whole -- which is how any system must somehow be understood -- child maltreatment appears as a tangled web of myths, half-understood relationships contradictory approaches to management tragedies, suspicions and unknowns. Fragmented perceptions and the divergent results they produce add to the inherent complexity of any attempt to define or deal with the problem.[8]

As we look back over the scope of the problem of child abuse and neglect, it is evident that society is now awkwardly trying to come to some kind of grips with it, as evidenced by the law, the publicity, training, etc.

Child abuse and neglect have long been known to protective services and many of the concepts of outreach, nurturance, parenting, self-help groups, etc., which are new to other allied professions have been standard operating procedures in social work for many years. They are now being used with more community sanction and with ever-growing success in CPS and other allied professions. The growing research of abuse and neglect adds small pieces of knowledge and practice wisdom to validate what has long been known by tradition and adds new insights and techniques to the field. Several points of research are worth sharing, as well as some discussion of new directions in the field.

Recent studies worth noting

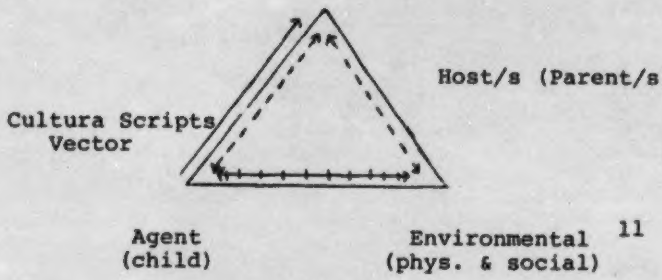
As good practitioners know, it's of utmost importance that one "keep up" with what is new in the field. It helps you keep in touch with peers, adds insight to your perspective, sharpens your skills, and last, but not least, improves services to your clients, agency, and community.

One of the most useful constructs to emerge this year is Rita and Justice Blair's (1976) description of child abuse in a psychosocial systems model approach. Building on the framework of Helfer, Kempe, et al. and extending Erikson's theories, the Blairs conceptualize abuse as a "life crisis, a prolonged series of changes, that predisposes one to abuse, not the situational disturbance that is simply an appendix to that life crisis."[9] Undoubtedly, one lives with the stresses and pressures of life, but it is the unpredictability of all kinds of changes, most of which are not related to poverty, that is accentuated. The stresses relate to interpersonal problems and losses which put one in a continual life-crisis whose end state is exhaustion, exhaustion being a decreased ability to adjust and at the same time an increased risk of losing control. Why this surfaces in child abuse and not psychosomatic illness, accidents, or injury is unknown. For child abuse to be the outcome, a critical issue is symbiosis (not a new idea). The parent does not separate himself/herself appropriately from his or her child. This sets up a destructive role reversal. The life-crisis premise leads to a situation often seen in CPS -- "there is constant competition over who will be taken care of."[10] This reawakens the adult's feeling that he or she is always losing the struggle to be taken care of. The recognition of continued life-crisis, competition and exhaustion as factors in child abuse are well worth noting.

In such a relationship, the spouses compete with each other; when one "loses" and has to take care of the other, he or she turns to the child in a last desperate effort to be taken care of himself or herself. When the child fails to meet the parent's need, a lifetime of frustration caused by unmet dependency needs is likely to be unleashed in aggression toward the child, especially if that parent has experienced a life crisis. This will be seen in struggles ostensibly over finances, sexual difficulties, living conditions, or in-laws. Often the abusing parent believes his or her spouse has a closer relationship with the child than he or she does, is more inclined to say it is difficult to get the spouse to discipline the child, make decisions, or accept responsibility.

The public health framework which the Blairs use to describe the abuse is not new, but it fits the system that the worker is in more aptly than other frameworks and connects where narrow approaches leave off. It is a psychosocial approach, viewing the client's life space as a series of systems -- the family, the environment, and the culture, with all of the transactional and interactional events that occur in these systems.

The question then becomes, how does the client maintain or lose his or her homeostasis (balance) within this framework? The what and the how are where the interventions will be aimed. Of course, in intervening, the workers also become part of that schema and, as such, must be aware of how they use themselves in the situation.



This new view really notes the constant hunger and competition between spouses to be taken care of and the destructiveness of involving a child or children in this struggle. It offers a broad view which gives the worker a more realistic framework to really understand abuse. What is it that supports abuse, and reinforces the abusive climate as a means of coping and maintaining a family homeostasis must be assessed before meaningful interventions can be made.

Another piece of knowledge to add to what we already know was discussed by E. James Anthony, M.D., at the 1976 National Center for Child Abuse and Neglect conference on "Treatment of the Abused Child." He studied and classified psychotic abusive families with whom observers had lived for one week periods. These he described as (1) involving parents -- paranoid-psychotic, schizophrenic parents or severe alcoholics; these are child-attacking parents, (2) non-involving parents - those who are severely depressed, chronically depressed, entirely involved in themselves and their psychosis. The reactions of observers in these family situations are worth noting. With involving parents observers felt engulfment and anxiety; they had nightmares, flight fantasies and alienation feelings of persecution and victimization. With non-involving families, observers felt a sense of abandonment and depression.

The children in these families had the same reactions. They also developed (probably because of their age) "ideas which were loose, confused and inappropriate affects. They felt on the attack, especially if part of the paranoid system of the parent. A lack of trust, poor sense of reality, and continued sense of abandonment and fear...." Dr. Anthony coined a phrase to describe this cluster of behavior which he observed in abused children of psychotic parents, "failure of the self."[12]

It was also found that children of psychotic abusive parents, despite abuse, were highly competent, successful in school, independent, had friends. These he called "superphrenics." However, they later on had some difficulty with close interpersonal relationships, for one of the means of coping in early years was distancing. This was so much a part of their defensive make-up, an overcompensation that made it difficult to accept the closeness of normal relationships.

New directions

One area frequently found wanting in the field of CPS has been receiving more and more attention in the past year, namely, the specific problems of social work in rural areas. The Universities of West Virginia, Wisconsin, Idaho and the Regional Institute of Social Welfare in Athens, Georgia, have initiated study in this area and have produced books, articles, video tapes, etc., which deal with those roles and aspects that are the distinguishing marks of social work as practiced in CPS in a rural area. More literature is also forthcoming on working with abused adolescents, abuse and neglect of children in institutions, sexual and emotional abuse, and the specific needs of abused and neglected children in foster care. All these topics will be presented in the upcoming training programs.

What seems to be emerging more and more is the fact that child abuse, the so-called "tip of the iceberg" is a catch-all for many problems. Perhaps as an offshoot of this, the need to diagnose, understand, and help "battered wives" is growing. Several centers have been established here, patterned after those in England.

Yet, with the cut-back in finances, services in local departments of social services are being sharply reduced, and agencies are looking more to the voluntary sector to give them support and assistance in treating clients.[14] Joseph Goldstein, commenting on this idea, noted that while DSS does a laudable job in crisis intervention situations, it is up to the voluntary sector to plan, nurture and provide continuity for the child's needs. Most local public agencies are working with CPS clients and do not have the resources to provide treatment, so the need now is to build the bridges to other agencies that can provide these services. CPS workers will play an increasingly important role as consultants to voluntary agencies, enabling them to learn about our clients' needs and carry their share of the burden.

Conclusion

In the past two years, the training project has focused on imparting to beginning CPS workers and direct line supervisors the core elements of attitudes, knowledge, and skills needed to work successfully in CPS.

The problems of abuse and neglect are age-old. The classic concepts of protective services are as successful today as they have been in the past. Because of the impetus of the Child Protective Act of 1973 - the legal mandates and public education campaigns, much interest and beginning support from allied professionals in the community are forthcoming.

New bits and pieces of knowledge, research, and practice skills are emerging. However, the fact remains, the problems of abuse and neglect are still tremendous. What now seems to be more clearly apparent is the need to coordinate the community services needed to work on these tasks. A key figure in the interplay between the client and the community will be the CPS worker and supervisor.

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Applications of Transactional Analysis to the Problems of Child Abuse and Neglect

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It would be a legitimate question to ask why Transactional Analysis, or TA for short, should be seriously considered for application in the extremely difficult and complex areas of child abuse and neglect. Since the publication of Eric Berne's Games People Play in 1964, there has been a veritable deluge of popular books and articles on TA. Because of the rather "modish" or "pop" quality of many of these writings, it would be easy to dismiss TA as more suitable for cocktail party banter than for application to serious behavioral problems. However, this would be to overlook the valuable clinical and conceptual work done by Berne and some of his more serious followers.

In fact, TA has shown considerable potential for training, consultation, and research in the broad field of child welfare. It has been successfully used in the training of child care staff in institutions and group homes. It was particularly successful in a demonstration program conducted in Buffalo, New York, for the training of foster parents in helping them deal with the problems and behaviors of delinquent adolescents who were placed in their homes (Dunham, 1974).

Some of the potential advantages of TA for work in the areas of child abuse and neglect are the following:

1) It can provide a relatively simple and clear understanding of the dynamics underlying cases of abuse and neglect.

2) It can provide insight into and control of the protective worker's own feelings and actions in the emotionally-laden area of child protective service.

3) Clients, too, can be provided with new tools, via TA concepts, for understanding themselves and for more effective use of their own potential in dealing with child-rearing problems. These tools and concepts are easily communicated to the client, and they are of a practical nature, so that they can be quickly implemented in practice.

4) There is an emphasis on contracts in TA treatment. This is particularly useful in specifying the objectives and evaluating the outcomes of protective practice. TA provides clear definitions and concepts with empirical referents (behaviors) for assessing the effectiveness of intervention. This enhances the research and evaluation potential of programs and services which incorporate TA concepts and tools.

There are actually four kinds of analysis included in TA theory and practice: 1) structural, 2) transactional, 3) games, and 4) script.

Structural analysis is concerned with the individual personality and what is happening within the individual with regard to feelings and motives.

Transactional analysis deals with what people do and say to one another.

Game analysis concerns itself with ulterior transactions between people that lead to certain predictable, characteristic payoffs.

Script analysis involves the study and understanding of specific life dramas that persons compulsively play out. This could also be called life-plan analysis.

It is the first two types of analysis, structural and transactional, that I should like to focus on here, because they seem to have the most immediate value for practical application in dealing with child abuse and neglect.

Structural analysis

The basic concern in structural analysis is with ego states. Berne (1966) has defined an ego state as "a consistent pattern of feeling and experience directly related to a corresponding consistent pattern of behavior" (p.364). The three ego states are colloquially referred to as the Parent, Adult, and Child and they are represented in the familiar P-A-C diagram shown below:

P - Parent ego state related to nurturing and critical behavior
A - Adult ego state related to problem-solving behavior and rational thinking
C - Child ego state related to enjoyment, laughter, and rebellious behavior.

From the point of view of internal (structural) dynamics, we can say that the individual is constantly recording what he is feeling (C), thinking (A), and deciding (P). The behavior exhibited by the individual at any one time gives us a clue to what ego state he is in.

The Parent ego state will reflect the range of behaviors of most parents - nurturing and sympathetic on some occasions, or critical, punitive, moralizing and prejudicial at other times. If a child has nurturing parents, he or she will develop a Parent ego state characterized by nurturing behavior. If the parents were characteristically critical and punitive, the child is apt to exhibit the same characteristics. From a more general perspective, the Parent ego state is the transmitter of cultural and family scripts. It is crucial for the survival of the human race, because it facilitates the automatic performing of parenting tasks and frees the Adult ego state to handle the more complex problems of modern life.

The Child ego state includes the inner world of feelings, experiences, and adaptations. When the individual responds as he or she did in childhood, whether playful, selfish, mean, manipulative or whining, he or she is responding from this state. There are three parts of the Child ego state: 1) Natural Child, 2) the Little Professor, and 3) the Adapted Child. The Natural Child represents the very young untrained, impulsive small child in each of us. It is self-centered and pleasure-loving, responding with affection when needs are met or angry rebellion when they are not. It is also called the Free Child because it has not been affected by parental or other societal strictures.

The Little Professor represents the unschooled wisdom of the child. Developmentally, it can be said to be operating anywhere from two years of age onward. It is highly intuitive, responding to non-verbal messages and hunches. It is also highly creative in figuring out how to get results by appropriate or manipulative behavior.

The Adapted Child displays the modifications and adaptations of Natural Child impulses resulting from training, experience, trauma and parental demands. The Adapted Child is apt to do what the parents want him to do whether the parental demands are rational or irrational. In addition to the more positive politeness, considerateness and civility, there can be negative adaptations in the form of withdrawing, procrastinating, or slavishly complying.

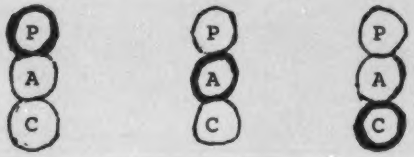
The Adult ego state is used to reason, to analyze and test reality, estimate probabilities, minimize the possibility of failure and increase the possibility of success. It is the state we would most like to enhance in our clients to enable them to solve their own problems.

The following chart, developed by Woollams, Brown, and Huige (1974, p.6) provides a list of behavioral clues associated with the ego state components of Critical Parent, Nurturing Parent, Adult, Free (Natural) Child, and Adapted Child, respectively.

CP	NP	A	FC	AC
WORDS				
bad	good	how	wow	can't
should	nice	what	fun	wish
ought	cute	why	want	try
must	tender	practical	won't	hope
always	splendid	quantity	ouch	please
ridiculous		probability	hi	thank you

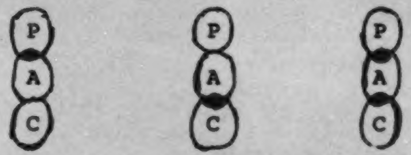
CP	NP	A	FC	AC
VOICE				
critical	loving	even	free	whiny
condescending	comforting		loud	defiant
disgusted	concerned		energetic	placating
GESTURES OR EXPRESSION				
points finger	open arms	thoughtful	uninhibited	pouting
frowns	accepting	alert	loose	sad
angry	smiling	open	spontaneous	innocent
ATTITUDE				
judgemental	understanding	erect	curious	demanding
moralistic	caring	evaluation of facts	funloving	compliant
authoritarian	giving		changeable	ashamed

There are certain pathological problems that occur with regard to ego state boundaries in certain types of personalities. One such problem is the exclusion of the other ego states by one having rigid ego boundaries, as in the following diagram:



These have been referred to as problems of the "constant parent," the "constant adult" and the "constant child." These represent, of course, very poor adaptations for dealing with most personal, social, and parenting tasks.

Perhaps more important for understanding some kinds of parenting involved in child abuse and neglect situations is the problem of contamination. This is characterized by an intrusion of the Parent ego state and/or Child ego state into the boundary of the Adult ego state as shown here:



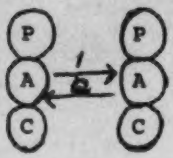
In these instances the Adult accepts as true some unfounded Parent beliefs and Child distortions. In extreme cases, contamination by the Parent is experienced as hallucinations -- the sensory perception of things that are not real. Thus, the abusive parent who says "God told me to beat my baby," is suffering from such a contamination, and the children of a psychotic parent like this are in extreme danger.

Contamination by the Child is experienced as delusions in severe cases. The belief on the part of some abusive parents that their infant children can meet their (the parents') own infantile needs is an example of such contamination. The irrationality of this type of role reversal is explained by the contamination of the parent's Adult by his Child, which prevents him from objectively seeing the patent inability of an infant to provide him with the love and nurturance he craves.

Transactional analysis

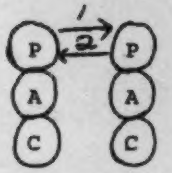
Anything that happens between two people will involve a transaction between their ego states. An observer should be aware of the gestures, facial expressions, body posture and tone of voice as well as the verbal messages in order to understand the nature of the transaction. All transactions can be classified as; 1) complementary, 2) crossed, and 3) ulterior.

A complementary transaction takes place when a message from an ego state in one person gets the predicted response from the ego state to which it was directed in the other person. Some examples of such transactions are given:



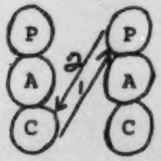
Adult/Adult information transaction:

1. What time is it?
2. Half past five.



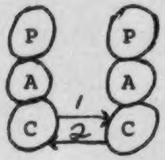
Critical Parent/Parent transaction:

1. Isn't it awful the way Suzie teases her kid brother?
2. Yes. We must chastise her for that.



Nurturing Parent/Child transaction:

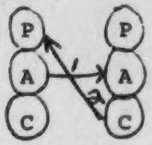
1. Will you stay home tonight, Mommie?
2. Yes, dear. Don't worry. I'll be here if you need me.



Angry Child/Child transaction:

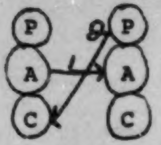
1. Do you know where that damn kid of ours is?
2. I've spent an hour looking for him. I'll kick hell out of him when he gets home.

Crossed transactions occur when an unexpected response is made to a stimulus. An ego state is activated unexpectedly and the lines of transaction are crossed. These lead to feelings of pain and resentment.



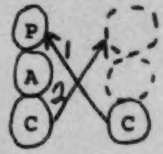
Husband: 1. What time is it?

Wife: 2. Why are you always rushing me?



Child: 1. Do you know where my gloves are?

Mother: 2. Right where you left them. Can't you remember anything?

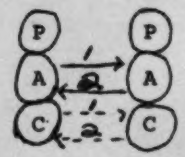


Mother: 1. Do you love me, honey?

Infant: 1. Cries (due to some internal discomfort).

This last transaction poses a potential abuse situation in that it represents the characteristic sort of role reversal engaged in by abusing parents in which they have unrealistic expectations of the child. In this instance, the mother expects her own infantile emotional needs to be met by a child who is too young even to have a Parent (or Adult) ego state to respond from.

Ulterior transactions always involve more than two ego states. An ulterior transaction is disguised under a socially acceptable one. One transaction is at the social level while the other is at the psychological level.



Mother: 1. It's time for you to go to bed. (Ulterior - I've had it with you. I want to be alone.)

Child: 2. Why? (Ulterior - I want you to pay attention to me.)

Such ulterior transactions are characteristic of psychological games and rackets. They lead to emotional "payoffs" for individuals that can only be unsatisfactory and self-defeating or destructive in the long run.

Life positions

Usually between the ages of four to seven, children develop a concept of their own worth and the worth of others. Their experiences are crystalized and they come to a "decision" about their place in life, particularly in regard to others. If the decision is made too soon in a child's life, it is apt to be distorted because of the infantile state of the ego. Severe abuse or neglect of an infant or very young child would be dramatic examples of situations in which such distorted decisions are made. The resulting pathology then leads to intergenerational passing-on of distorted decisions.

The first life position is, "I'm O.K., You're O.K.," which is the potentially mentally healthy one. Such a person accepts the significance of himself and others.

The second position is, "I'm O.K., You're not-O.K.," which is called the projective position. Such people tend to feel victimized or persecuted. They blame others for their miseries. Criminals, delinquents and paranoid individuals are generally of this sort. In extreme cases this position can lead to homicide and sadism. Someone who had been severely physically abused as an infant or very young child would be apt to make such a distorted decision.

The third position, "I'm not-O.K., You're O.K.," is called the introjective position. It involves feeling powerless in relation to others and leads to withdrawal, depression and in severe cases to suicide.

The fourth position, "I'm not-O.K., You're not-O.K.," is known as the futility position. It is characterized by little or no interest in living and by schizoid behavior. In very extreme cases it can lead to suicide or homicide or both. This position is clearly the one delineated by Polansky in describing the "apathetic-futile" mother so commonly found in child neglect cases (Polansky, DeSaix, Sharlin, 1972).

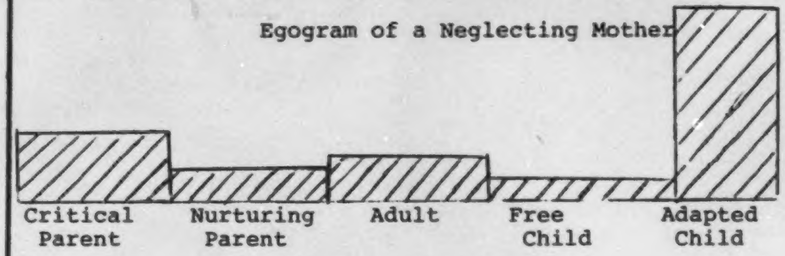
The process by which abusing and neglecting parents assume these distorted life-positions is well illustrated by Ray Helfer's (1974) "World of Abnormal Rearing Cycle" shown on the next page.

The unrealistic expectations and role reversal by their own parents leads to a compliance in which childhood is missed. This explains the apathy and lack of joy (Natural Child) in their lives. Trust is not learned, and in severe cases this can lead to life-positions two and four, in which others are viewed as not-O.K. The resulting isolation and lack of positive strokes or the continuous negative ones (discounts) received lead to the "I'm no damn good" ("I'm not-O.K.") position. The whole process of relating to others in selecting "friends and mates is fraught with substitute behaviors, games, and rackets, rather than with authentic intimate relationships. Thus, problems of separation and divorce ensue and the whole cycle of abnormal child rearing is begun again.

TA tools for diagnosis and treatment

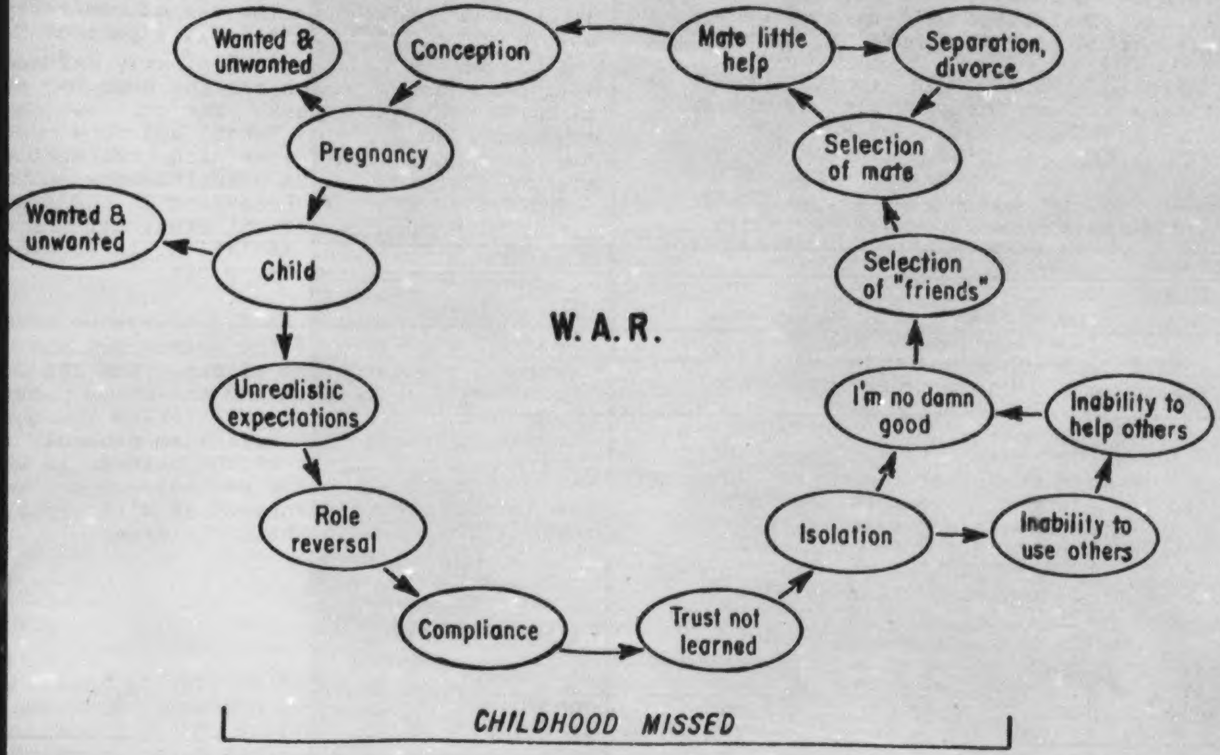
A very useful tool in structural analysis is a diagram of a person's ego states as illustrated in the form of an "egogram." The bars in an egogram represent the relative strength and prominence of each ego state or major components of ego states. The following egogram is based on an actual neglecting mother who would aptly fit Polansky's description of the "apathetic-futile" type:

Egogram of a Neglecting Mother



The most striking feature of this egogram is the prominence of the Adapted Child. The adaptation represented here is essentially a negative rather than a positive one. It is a basically passive adaptation. This mother displays a passive compliance in her interactions with the social worker assigned to her case. Whereas she appears to go along with

World of Abnormal Rearing Cycle


Wanted & unwanted
Conception
Mate little help
Separation, divorce
Pregnancy
Selection of mate
Wanted & unwanted
Child
Selection of "friends"
W. A. R.
Unrealistic expectations
I'm no damn good
Inability to help others
Role reversal
Isolation
Inability to use others
Compliance
Trust not learned
CHILDHOOD MISSED

From A Self Instructional Program of Child Abuse and Neglect, by Ray E. Helfer, M.D. By permission of the author.

casework plans to remedy the neglect situation, in reality there is an underlying negativism which expresses itself in a passive resistance -- a persistent failure to undertake any of the necessary, agreed-upon steps in the remedial plan. The Adapted Child is also evident from the whining quality of her requests to her spouse and children. Instead of expressing her wishes in the straight forward way of the Free (Natural) Child, she will tend to engage in a rather half-hearted form of wheedling, at best.

Her Free Child is almost completely flattened or non-existent, and her own personal history clearly indicates that her childhood was missed. Further, even the simplest of tasks seem to be beyond her, and it appears that she does not have the ego energy necessary for most decision-making, or for ordinary goal-directed activities. Consequently, her Adult is quite weak and lacking in prominence in her egogram profile.

As would be expected with chronically neglectful parents, this mother's Nurturing Parent is very low. There is practically no actual demonstration of emotional or physical stroking or nurturing of her children by her.

Finally, her Critical Parent is not remarkably high, but it is more prominent than the other ego states, excepting the Adapted Child. This aspect of her personality is expressed in a pervasive, but not intense, criticism of her children.

The egogram can be a useful tool in helping a client to gain some self-insight, and in fact to set up a treatment contract. Brechenser has noted that about fifty percent of first (intake) interviews lead rather naturally into a discussion of ego states (Brechenser, 1972, p.175). Thus, within the first few interviews it is possible for most parents to relate to the simple graphic portrayals of ego states represented in the form of an egogram.

The simple terminology of TA concepts, particularly the ego states, enables clients to objectify themselves, their feelings, and their behaviors in a relatively easy, non-threatening way. Thus, they might be able to interpret particular behavior on their part by saying something like..."My angry Child was acting up," or "I was coming from my critical Parent when I did that." This puts their interpretations in the third person, and makes such interpretations much easier and less threatening than if they had to say "I felt this," or "I wanted to do that."

Another tool of TA that has clear value for casework in abuse and neglect cases is the treatment of contract. Although the use of contracts is not unique to TA, it is invariably a part of TA treatment and the stress is always on clearly defined and measurable goals, which are the best for the purposes of child protective work. The contract should emphasize questions of "what" and "how much." For example, in their work with treatment groups of abusive parents, two TA practitioners emphasized the reduction of specific behaviors in the areas of violence, management of children, talking and sharing with mate, and social isolation, in setting up contracts (Justice, 1975, p.39).

In TA, contracts should always be made between the Adult ego state of the worker and the Adult and Child ego states of the client. For the client, the Adult provides the data and the Child provides the energy (motivation) for undertaking the necessary changes. The contract will also probably involve "homework" on the part of the clients in which they are held responsible for recording their ego states and characteristic transactions with significant others, particularly their children.

Conclusion

It should be noted in closing that the TA concepts and techniques discussed here are intended to supplement, not replace, good, sound social work intervention in child protective situations. There is no short-cut to informed, basic psychosocial diagnosis and treatment. The complete range of supplementary and supportive social services must be made available to these families. No single psychotherapeutic approach such as TA can hope to handle all the complex and manifold social, economic and psychological factors leading to the problems of child abuse and neglect.

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Treatment of Abusive and Neglectful Families

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This article is designed to help the social worker develop treatment skills in protective services. It may also be used by other treatment people who encounter the abusive and/or neglectful family in their work. A great deal of the content was developed from material presented by Doctors Helfer and Kempe.

The objectives are to understand treatment in terms of assessment, achievable goals, and use of self in accomplishing goals. More specifically, in organizing an assessment, one must know what the client sees as a problem, what society sees as a problem, what situation the client lives in and what strengths and potentials she/he has to work with. In looking at the assessment and developing goals, one should look for overall, long-range goals and then break these down into specific, achievable goals. In order to accomplish stated objectives, one must know how to use one's self as a tool. This means that the worker should be consciously aware of how she/he can act as a catalyst in helping the client alter his situation. It is important to note that the worker should not "take over" the client but work together with him.

Dynamics

In thinking about assessment, it would be helpful to review some of the common dynamics of abusive and neglectful families. The parenting is often erratic or withheld. The child may have experienced early loss of a previously nurturing parent. The parenting figure who is present may turn to the child for nurturing and expect the child to respond as a giving adult. The child responds to this in self-defense and tries to comply with parental wishes. This leads to a lack of trust in the child and may result in a tendency to present a compliant facade. Meanwhile, the child experiences an underlying rage at never having his own needs met and feelings of worthlessness because he never felt valued or cared for. Another common result is low impulse control. This results from learning to "get it while you can" because it may not be there tomorrow. The "it" could be anything from food to a hug.

If a person doesn't have his needs met as a child, it is hard for him to grow beyond his childish ways. This may result in an adult whose behavior is more appropriate for a two-year-old. This may also result in defenses that are common for a small child -- denial and projection. It is not unusual to hear, "If Johnny didn't tell, I wouldn't be in this trouble" or "I don't have a problem. Everything is fine."

Such feelings and ways of coping will result in an inability to risk and invest in relationships. This may lead to an inability to use others for support, inability to give to others, social isolation, and a preoccupation with one's own needs. All of the above are very influential in the formation of "friendships" and in the choice of a mate. The chosen partner will often reinforce the low self-image, be unable to give consistent support, and be a party to creating stressful family situations.

The above dynamics will lead to a crisis-ridden life for the grown child. In crisis, the grown child will turn to his own children and the cycle will begin again. It is important to remember that anything that makes demands on such a person may be perceived as a crisis.

Treatment goals

Treatment goals must follow from an understanding of the above dynamics and an individualized assessment of the client and his situation. The goals must be realistic and limited to the capabilities of the parent. Expecting the impossible frustrates and angers the worker when the parent does not succeed and reinforces the parent's low self-esteem.

Some generalized goals for abusive and neglectful families are to help them grow out of isolation, achieve a new sense of self-worth and enable them to find new ways of coping with stressful situations. Helen Alexander's concept of realistic goals are that:

1. The child be able to live in safety.

2. The child be accepted as an independent being in his own right, and

3. The parent be able to respond to the child's needs comfortably.

She notes that the parents' style of child rearing will probably still be rigid and their ability to tolerate stress and demands limited. The important thing is that they learn how to use others in times of crisis. (Kempe and Helfer, p.40).

In a video tape produced by SUNY Buffalo (Saunders, Goal Oriented Interviewing) it is suggested that there are five steps in goal planning. They are involving the client in choosing goals, making reasonable goals, giving a description of the client's current behavior, setting a time frame for accomplishing the goals, and delineating the tasks that both the worker and client should carry out to accomplish the goals. These are excellent guidelines and can be used in the process of the interview to arrive at a mutual and specific understanding with the client.

Process of treatment

Self-awareness. Establishing a positive therapeutic relationship with the parents is the most important step in protecting a child in his own home. This can only be done if workers are aware of their own feelings and predispositions. They must be able to handle their own anger and anxiety before they can adequately cope with clients' traumas.

Upon a worker's first encounter with a family, she/he may want to deny that they could do such horrible things. Awareness of this tendency is particularly important if the worker is considering closing the case or reporting it as "unfounded." When the worker is positive about the occurrence of abuse or neglect she/he may then experience feelings of horror or anger. These feelings may lead the worker to deny the situation, "punish" the parents, "rescue" the child or abdicate all responsibility because the parents are too sick to help. In terms of the worker's behavior, she/he may remove the child, but only be able to support the action in emotional terms. She/he might also have so many emergencies that a particular client is rarely seen. The key to self-awareness is to be able to realize when one is reacting emotionally and to examine why. A good beginning might be to ask oneself what the reasoning is for a particular decision or behavior.

Awareness of self, then, is imperative and should co-exist with the knowledge that the parent is very childlike and will respond to life situations in a childlike manner.

Placement. In protecting the child, the worker must often decide whether or not placement is necessary. Two major considerations are the safety of the home and what one hopes to achieve in placement. The safety of the home is determined by the age of the child, severity of the abuse or neglect, parents' potential, safety valves for the family, actual characteristics of the child, and nature of the crisis.

The age is important in determining the child's ability to defend himself and the severity is especially important in light of the child's age. A broken limb in an infant is an important sign. The parent's potential is determined by checking how closely their history and present situation are aligned with known dynamics. The characteristics of the child are important because the child himself may present problems which make him a target for abuse and neglect. Safety valves may include support for the parents, child care resources outside the immediate family, and the parents' actual use of these supports. The nature of the current crisis is important in realistically evaluating anyone's ability to function in such a situation and in determining the relationship of the reaction to the severity of the situation.

If the responses to these questions point to imminent danger for the child, removal is paramount. If not, other alternatives should first be considered.

Other issues that must be realistically dealt with are the effect of placement on the child, the attitudes and capabilities of available foster parents, the length of placement, and the legal basis.

The effect of separating parent and child, even in abusive and neglectful families may be very traumatic for the child. It is necessary to consider whether the effects of being separated from his parents would be less traumatic than his remaining in the home. The foster parents must also be willing and able to handle a child with a myriad of behavior problems. If placement is bound to be a failure, will it help the child? Since long- and short-term placements are known to have different effects on the child, it is necessary to evaluate each situation in its own time frame. It is imperative also, to have a legal basis for placement. There must either be consent or sufficient evidence to present in family court.

Handling Resistance and Establishing Relationship. The treatment relationship is developed in order to help the client achieve self-esteem, participate in constructive relationships and cope better with stress. To this end, the worker must be aware of the client's enormous dependency needs and inability to trust. The client's behavior may then seem inconsistent; the dependency will appear in almost desperate requests for help and the mistrust in resistance and anger.

In order to deal effectively with resistance, the worker should know where it is coming from. The client expects to be attacked as a bad person and already has great feelings of inadequacy. He needs to protect himself from this and from expected failure in the relationship. He may also be afraid of upsetting his precarious equilibrium, resent the worker's authority, fear legal intervention and loss of his child.

The client may show this in direct verbal resistance, physical avoidance of the worker, use of distractions such as television, children, and friends, avoidance of issues in the interview, feigning illness or inability to cope, projection of the problem onto others, or denial of the existence of a problem.

The worker may react with inability to use authority because of fear of losing the client, desire to be liked, reciprocal anger and rejection of the client, or she/he may be immobilized by anxiety and unable to form a focused treatment plan. The worker may also avoid seeing the client or dealing with issues and feelings, or deny that the client needs or wants help.

There are several things to keep in mind when coping with resistance. Workers must deal with the realities of their concern and be clear about why they want to become involved with the clients. It is important to be non-critical so that low self-image is not reinforced. Consistent, supportive, firm intervention over many months may be necessary before the parent will talk openly with the worker. Oftentimes, concrete, tangible intervention such as housing or child care may be helpful in beginning to establish trust. The interview should be focused and deal with one manageable problem at a time. It is also important for the worker to express verbally to the client recognition that the client has been trying very hard under unusually difficult circumstances.

If all efforts fail, court intervention may be necessary. When the child's welfare and safety are in jeopardy or when placement is indicated the worker may have to use the family court process. Court involvement can be used constructively in a case to insure a family's participation, build evidence for future placement or adoption, or to move immediately for protection of the child through placement. In such cases the worker must be honest with the family and be able to interpret the use of authority as caring and not as a threat. The worker must be able to handle his/her own feelings about being in a position of authority and resist either abdicating responsibility or using it as a punishment. The client will respond to this responsible caring positively, in spite of verbal expressions of anger. The worker should verbally recognize the client's realistic basis for anger, accept the feelings and help the client work toward extricating himself from the situation. When the client sees that the worker is caring, warm, and trustworthy and accepts him in spite of "knowing all," he will begin to envelop the worker with overwhelming dependency needs. The worker will become the nurturer the client has always sought. The worker must again handle his/her own feelings. She/he must be able to respond in a caring way without being controlling or manipulative. "Advice is often sought by parents whose pattern is to determine others' expectations, in order to gain a sense of worth." Because this is flattering it is a tempting trap for the worker which must be carefully resisted. (Kempe and Helfer, 1972, p.25).

The worker must also be aware of the dynamics of mistrust throughout the relationship. In spite of the client's dependency, there may never be a time when he completely trusts the worker. The worker must recognize

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this and continue to pursue the client, be consistent and punctual in keeping all appointments, and be aware that every move may be interpreted or misinterpreted by the client. Even inadvertent slipups on the worker's part may be seen as evidence that the worker doesn't really care. The worker needs to acknowledge the parents' underlying rage and be able to deal with their unmet needs and lifelong insecurities. This demands a great deal of patience and tolerance from the worker.

Through the relationship that develops, the parent will be able to look to the worker for support, instead of to the child. As the parents' needs are met, they will, in turn be able to give to the child.

Treatment focus

All through treatment the worker is using the relationship to help parents resolve their problems with trust, self-worth, isolation, and use of resources to meet their needs. It is, however, difficult to talk to the client about his need to trust the worker. In the interview, the worker should focus on what is currently important to the parent. It is necessary to set immediate, limited and achievable goals with the parent. These goals must be mutually arrived at and agreed upon by the worker and client. Tasks for both worker and client must then be determined. For example, in order to build the helping relationship, the client may agree to see the worker every week and the worker may agree to help the client obtain some concrete resources such as new housing or a homemaker. The tasks agreed upon may be less tangible. In working on such things as relationship, the worker may help the client look at his behavior with the worker. By doing this, the client may be able to see ways in which he can be self-destructive and ways in which he can build relationships. If the client has some capacity to think this through he may be able to transfer this learning to other relationships. In order to build self-esteem, the worker must help the client feel proud of his accomplishment and know that others see him as a worthwhile person. To achieve this, the client must first be able to trust the worker. The worker should then help the client find alternate ways of meeting his needs and encourage the clients own competence in problem solving. The worker may also help the client to learn new ways of reality testing, by carefully examining all factual aspects of a situation, and to find alternate means of expressing anger.

The worker must be careful of pushing the parents or making demands on them. If the parent is not meeting the worker's expectations, there is always a reason. It may be the nature of the expectations or something about the parent that the worker does not yet understand. The worker must also be aware that sometimes parents feel that she/he is making demands on them whether she/he is or not.

It is imperative that the worker remember that words are not always trusted. Behavior and attitude are the most effective way to communicate with the client and to give meaning to words. Learning and growth are experiential; not all parents can develop a great deal of insight, but most all can learn from the experience of a relationship. (Helen Alexander in Kempe and Helfer, 1972).

Termination

Criteria for growth and improvement are taken from the established goals. One clear indicator is the way the parent reports handling crisis and stress. Early in treatment the client reports numerous crises and seems overwhelmed. Quite often the incidents are blown out of proportion. The client will begin to figure out ways of dealing with these situations and seek approval from the worker. Finally, he will be able to report with a sense of pride and achievement how he handled the crisis. He will also have increased his ability to find supports outside of the treatment relationship. Another indicator is that the parent will be able to see the child as an individual instead of an object of satisfaction. At the same time, it is hoped that the marital relationship will be strengthened if possible or abandoned if it is too debilitating. It is important not to terminate treatment too early even if the parent requests it and the initial crisis is past. A checklist of criteria is necessary so that the worker is sure of the client's growth and development.

Handling termination with a client is as important as building the relationship in the beginning. It is Kempe's and Helfer's belief that the relationship between the treatment person and the parent should never be completely terminated. They believe that although frequency of contacts diminish, the client should know that the worker will be there if needed. Although this might be an ideal situation, it is rarely possible. Because of the worker's changing of jobs, bureaucratic changes in policy, client movement and other variables, there will often be occasions when termination must be dealt with. Even for long-term workers, it is essential to deal with the client's feelings about cutting down appointment times. To this end, the worker must return to dynamics and recognize the feelings that will be aroused in the parent. The client will experience doubts, fears, mistrust, anger at being "deserted," and feelings of isolation. The worker must recognize these feelings and discuss them with the client. After recognizing feelings of loss, the worker should be supportive, pointing out the realities and strengths of the relationship. The worker should also help the client see how he has grown, reinforcing a positive sense of self. It is important for the parent to know that he can call the worker in times of stress or that an alternative support system is available. To end the relationship badly would eliminate many of the gains the worker and client struggled to achieve.

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Incest: A Beginning Look at Assessment and Treatment

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The impetus for this paper was provided by the lucid statement of a DSS supervisor that the reason incest remains hidden from most caseworkers is that they not only do not know how to recognize incest, but they don't want to. For in fact, how would they deal with it once recognized? It is my opinion that we, as workers, can deal with anything we can understand, anything we can form a mental picture of. This paper is not meant to be a scholarly presentation of the subject, but rather an empathic summary of the key elements present in the incestuous environment, which are clues to both the diagnosis and treatment of this family problem.

With this understanding, workers will, it is hoped, be more able to recognize the clues they come across, and begin to trust their instinctive reaction that "something is wrong here."

To limit our discussion, I will focus on father/daughter incest of an ongoing nature. As you will see, incest requires the cooperation of both parents. If this cooperation is not present, the incident will be found out and it should then be treated as a trauma. Sibling incest, is not dealt with here because it is too often confused with normal sexual curiosity and sex play.

Incest is long established in history, as attest Biblical references and the ancient Greek tragedy, Oedipus Rex. History also traces the taboo to a tribal function meant to force men to marry outside their tribes to increase their numbers. Not all the references are negative: history tells us that incest was practiced in the Middle Ages as a cure for syphilis (Durkheim, 1963, p.70). Freud states that incest is an instinctual drive that man strives to suppress,thus the strong taboo is in direct relationship to the strong drive for it (Freud, 1950, pp.141-145). More modern writers, like Albert Ellis, state that incest occurs more often in the minds of the therapists than in actuality (1963, pp.124-125). R.E.L. Masters takes a middle of the road position: if there is no victim, there is no crime (1965, p.44). Thus, he would say, the taboo should only be enforced where it would threaten family structure.

There are several clues for the diagnosis of incest. Although these are often mistaken for causes, they are more appropriately viewed as flags to alert the worker to the possibility of incest. One such clue is overcrowding. Certainly, many families lack privacy and do not succumb to incest. However, overcrowding remains a factor that can help create a milieu conducive to incestuous sexual activity.

Another factor might be the separation of a parent from the child by incarceration, armed service or divorce. For example, a father returning home after an absence of several years may see his daughter in a different perspective. The normal parent/child relationship has been interrupted.

Another factor, especially in families with step-parents, might be an unnatural age difference between parent and child. I can recall one family where the mother, who was only 11 years older then her step-son, told me that sexual tension was the reason he had quit school and joined the service. Her attitude was a classic one for promoting incestuous development. The son was more satisfying to her than her husband. The son was thoughtful, sensitive, complimentary, and by comparison the father fell far short. Rejecting her husband, she sought to replace him with the son. The son felt the tension and dealt with it in a very appropriate manner -- he fled the situation.

More often it is the unconscious behavior of a parent that is a clue. Over-possessiveness is an obvious one. The father who refuses to allow the child normal outlets unconsciously wants to keep the child as his exclusive property. He also fears that if he sees the child as a sexual object, so may others. The parent who is an exhibitionist also merits consideration. Appearing naked in front of the child or bursting into his bedroom unannounced are the acts of a parent who has the need to call attention to himself and his body. Sleepwalking may also be a flag. The parent feels that, if the act is committed while sleepwalking, there is no blame. Insomnia is the reverse side of the coin; the parent is afraid to sleep for fear he will act out his fantasies. Alcoholism is a behavior that protects the parent on both sides. Perhaps he will become so drunk that he will pass out before incest can occur, or if the act is committed while drunk, he cannot be held accountable. A less obvious behavior that also serves as a clue is romping play. Many workers have viewed a child and adult playing and had the uncomfortable recognition that there was a sexual overtone to the situation.

All of these are clues, danger signs for us to react to. At most, they contribute to the incestuous environment, an environment where several forces come together without any of the normal restraints to prevent their influence. I would like now to focus on what we find underneath these clues, what kind of environment supports the development of an incestuous relationship. In other words, how did this situation which we are now confronted with (the fact of a long term sexual relationship between father and daughter) come to be. Most noticeable in the "picture of incest" is the role confusion and reversal of the main characters: father, mother and daughter.

The father probably has a family background torn by conflict and separation. His father most likely had a poor employment record, giving little stability to the family. He was probably abusive and demeaning to his son, leaving the son frightened and threatened by authority. The son not only received little warmth and understanding but also lacked models of healthy parenting in his life. The end-product is an insecure male who lacks much formal education, has sporadic employment history, and seeks to compensate for feelings of inadequacy by clinging to outside supports. He has failed to establish a masculine identity and on projective tests will more commonly identify with small soft feminine items. He is looking for paternalism to depend on and hide in. Thus, many of the incestuous fathers studied are in the military service. Large paternal corporations are also havens for this personality type. In fact, as long as the support of the government or the corporation is present, the incident of incest may be avoided, occurring more likely at a time of discharge or threats of layoff.

The incestuous father is an empty man, overwhelmed by responsibility. He might appear to be the boastful overachiever, maybe even heading service groups, active in scouting, the church. But inside he knows at any time he could be found out. The one person he may still be able to convince of his prowess is his susceptible young daughter. His wife has already removed herself from him, knowing there is nothing behind all that boasting and bragging. Let their daughter be impressed, at least he is no longer bothering her! And so the father turns to the young daughter for the warmth and support missing in his life.

The mother in this situation is every bit as empty and frightened as her husband. She is also angry. Like her husband she also had an unhappy childhood, her father was also cruel and may have deserted her. She has learned that you can't depend on men, only she let herself be fooled by this man who seemed so sure of himself. She is tired and wants someone to take care of her. Her daughter at least, listens to her when she complains about her plight. Sure, she shouldn't burden this little child with her problems, but she might as well learn just how life is. In this subtle trap she changes roles with her daughter. She begins to view her daughter as her mothering person. She allows her to discipline the younger children and take charge of her father; after all she seems to enjoy the role.

The child is the victim of the environment that was ripe for an incestuous relationship. She is unprotected, deserted by her mother. She hates her for this but still plays her game in the hopes of finally winning her mother's love. Her father's physical advances may also be the only form of affection she receives. In almost every instance, the young girl has entered the incestuous relationship innocently. As she reaches puberty, she may wish to end this cycle. But how can she? It would kill her mother and she has already had to suffer so much. The real subtle bind the daughter finds herself in is that she senses that her mother is in some way supporting the activity. After all, in all those years she must have sensed something, the clues were there. And what would disclosure do to the family. Her father would go to jail, the family might be broken up. No, she must somehow learn to deal with it.

This places the daughter in an omnipotent position in the family and they all know it. She can destroy them. They have to give in to her demands and treatment of them. This is quite often the point at which we become involved. We find not a six year old child who has been raped by her brutish father, but a shrewish fourteen year old who is cruel in her treatment of her parents. We are amazed that the parents don't smash her one for the way she talks to them. The mother is certainly not someone who sold her daughter into white slavery. She is shocked, crushed by the disclosure. She sits quietly sobbing, bewildered by all this. "How did this all happen?" Our hearts go out to her. We want to put our arms around her in a protective gesture. And to tell the truth, we are not even sure the girl did not seduce the father. Sure he may be guilty, but look at him -- beaten, crying, guilty, and ashamed. He's a steady worker, active in community work, maybe he was faced with middle age crisis and succumbed to the obvious seduction of this daughter. And that girl! You feel like really giving it to her! One thought crosses your mind -- "how will I ever find a foster home that will put up with this girl?"

If we forget how the first act of this whole drama got started, we fail in our treatment of the family. I stress family because they are all bound together in this struggle. No matter how the evidence presents itself now, the child was victimized in the most insidious way. She was robbed of normal family life. She was never valued as a child but as a sexual object, one that could make it possible for her parents to stay in an unhappy marriage. Much of the literature focuses on the child's trauma being resolved by her developing into a nymphomanic, a homosexual, a prostitute, or a frigid alcoholic. More commonly, her victimization lies in her future relationships with her husband and children. Yes, she will probably marry and even enjoy a normal sex life. This child who has been exposed to so much sexual stimulation will probably remain capable of sexual satisfaction on a physical level. However, emotionally she may see sexually gratifying her husband as a means of controlling him. With her children there is the unconscious fear that they have power over her, just as she did with her parents. She may even fall into being an abusive mother, hating her children for the helpless position they seem to place her in.

The destruction that an incestuous situation causes to the family and succeeding generations is reason to conclude that even with modern mores, incest cannot be condoned. In this statement, I am making a judgment about the family. It is a judgment about the treatment approach, not about the family as individuals. For in treating them, you cannot be influenced by personal repulsion or feelings of anger. For most of you, the treatment you provide will be all that is available. Maybe you are lucky enough to work in a county that has adequate mental health services, but even for you, the process of getting this family ready for professional intervention is an awesome task. Assuming that there is just you and your personal resources, I would suggest the following treatment approach. I feel that I must add that if you do not see your job as that of a Red Cross worker in a disaster, then you do not have the proper scope of the situation.

You will have to approach the entire family as nonjudgmentally as possible. Your first task is to establish proper roles. Use of self here is essential. Teach the mother her role, for example swap recipes, take cuttings from her plants, find areas to compliment her on, her ethnic background, place of birth, color of her eyes! Watch for any sign of improvement, i.e. some attempt at parenting. We need to encourage her to fit the solid role of mother and help her to derive some satisfaction from it. You are trying to displace the daughter and become the mother's confidante. She will be suspicious and reserved. No one has ever followed through on promises, why should she trust you?

At the same time, get the father to function more appropriately. You respond to him as if he were as capable as he pretends. Ask him things he can't fail at, something you already know he can answer. Ask him directions to some place, even if you already know, ask him to explain how he put plastic on the windows. Find out about him, where he served in the army, be dazzled that he has traveled out of state. This is no time for one upmanship! In doing so, you not only increase his feelings of self-worth and competency, but you raise his image in the eyes of his family. After all, you are the authority figure and you find their father worldly and interesting. In a family session where you have everyone gathered around the kitchen table, get him to tell old war stories. Use TV imagery. Thus, when the children are watching TV they will connect that with their father's experience.

I know these simple tasks can be difficult for some of the families we are presented with. In one family I worked with, there weren't enough chairs for everyone to sit down together -- let alone participate in family therapy. This obviously had to become our first task.

There are many methods for reestablishing the former roles that have become blurred. One approach I like is the use of photo albums if they are available. For the daughter it offers the opportunity to be that child she never was allowed to be. Get the parents to tell the children about their births, the description of how they felt looking through the window at the hospital at their baby. Reminiscing costs us nothing and is surprisingly satisfying. Here human nature serves us well, in that painful memory is denied and more satisfying images are substituted. Get the father out of the house as much as possible. Bring as much fresh air from as many different sources as your imagination can create. Approach them as a family but from several directions simultaneously. Get the children involved. Use the school, get the daughter to be a candy striper, volunteer, etc.

The task is anything but easy. This family has used incest to survive and you threaten them by wanting to take it away. They will fight you from all sides, they will fight you to the death. This is why I stress a family therapy approach. It has been the family secret that has bound them together and secrets will be the weapon they use against your intervention. I remember a family where the father was sleeping with the daughter. This had been made known to me by the mother in retaliation against the father after I had showed acceptance of him. Later when the mother was berating the daughter and listing the litany of her sins, the girl slyly lifted her head and announced that her father had slept with her the night before. Had this information not been dealt with openly between us all, I would have been quickly swallowed up in the complexities of intrigue.

Still, many of the problems are the same as you have encountered in cases of child abuse. You are dealing with the same kind of families. With child abuse we have to get beyond our initial horror of the subject. With incest we have a strong social attitude to overcome but until we do, we are of no value to these families. It is my hope that this paper will give you some of the tools -- the flags that give us the clues for assessment and treatment in working with victims of incest. Trust your instincts, if a situation looks suspicious, look into it from the angles suggested and treat where possible. Rarely will this be wasted intervention. The intent of this paper has been to introduce workers to the subject of incest. It is recognized that CPS workers will have additional concerns, such as the question whether to remove a child or not, which has not been covered within the scope of this paper. It is this writer's belief that some families can best be worked with while the child remains at home, whereas in other situations, removal would be the preferred mode of treatment, that you recognize in any family you assess. Review the treatment suggestions, judge if there is any potential for change and make a decision. The ramifications of either decision will have to be developed in an additional presentation. But, we all know that either decision is difficult and will require your investment of self to make it work.

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What Separation Means to a Foster Child

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Children placed in temporary or foster care for a planned period of time come from institutions, other foster homes, or their own homes. Regardless of their prior living arrangements, their new foster home involves a change of locale and of relationships. Families transmit a culture, guides for behavior, nurturance and the potential for emotional satisfaction. Children develop and define themselves through interaction with other human beings. Removal from a situation where the interaction was predictable, satisfying or not, constitutes separation, and the children in transition have to cope with a loss. It has been suggested by Thomas (1967, p. 184), Walker (1971, p. 194) and Littner (1956, pp. 121-140), that the period prior to and immediately following separation is of critical importance in the adjustment of the child and the foster family.

At the present time, there are approximately 300,000 children in foster care in the United States (Kadushin, 1974, p. 402). Most of the children are under five years of age and stay in care for an average of 12 months or less, but 25 percent remain in foster care for more than 36 months (Stone, 1969, p. 36). Some children live in free, work, or group homes but 95 percent are in foster family boarding homes (Kadushin, 1974, p. 418). Experienced foster families know, and data (Kadushin, 1974, p. 463) supports their observations, that children placed in their homes are from severely disorganized families who have suffered a series of upsets or traumas. Agencies have been providing more and better services to families in their own homes with the goal of keeping them together, if at all possible. It is, therefore, only in the most extreme situations of family disintegration that the children have to be removed for temporary care.

Some distinctions

For discussion, we will consider children beyond the infant and toddler stage. These children coming into foster family care have generally experienced some difficulties in relationships with their parents or have felt the impact of their parents' problems in coping with life or with each other. The foster child comes with a set or an attitude which is an unknown to his or her temporary family. As most foster families will attest, the getting-to-know-each-other period can be stormy, indeed.

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Foster parents learned to know their own children through a long series of verbal and nonverbal communications and interactions. They have given considerable thought to what action causes what reaction, have become adept at predicting behaviors and sensitive to their children's unspoken feelings and needs. Children within a family develop unique personalities, unique responses to controls, to tenderness, to comfort and to discomfort. Because of their familiarity with each other and with their patterns of acting, family members communicate relatively economically and effectively.

With the new foster child, there has been no history of building a relationship. It takes time, and during that time, many very important things are happening. The foster parent usually has some information about the child from the social agency: health, food habits, medication, school status, some characteristics of the care he has had, possibly some observations about his patterns of acting and reacting. With this knowledge and their natural warmth and caring, the foster family sets out to try to make the child comfortable and to understand him. The foster child, meanwhile, is also seeking to understand his temporary family, to see if he can trust them and to figure out why they want to care for him. He is interested to know where he fits in the family and if it is a family like the one or ones he has known. Rarely can the new foster child articulate these questions. Instead, he acts them out; he tests to see if people care about him, and if so, how much. As foster parents know so well, this can be annoying and upsetting to a whole household. Family members give out good feeling and often get anger or gruffness in return. It hurts to be told, "I don't have to mind you, you are not my mother." Foster parents can see, feel, and describe this and many similar rebuffs. They can understand the testing, the child's need to be reassured and comforted. It is often more difficult to understand that the child is also trying to cope with a loss.

The foster child's biological family was upset and he was often hurt and confused. He may have had less than ideal nurturing and guidance. But, he knew the place and the people. He may have learned how to conduct himself and under what circumstances he was viewed as good or bad. Foster parents have had experience with a foster child running away from their comfortable, caring homes to return to the situation of turmoil from which he was removed. With all the turmoil therein, the child had acquired a sense of familiarity, some balance and equilibrium; he knew what to expect. Even after pre-placement visits, a new home is a relative unknown and the foster child has lost his balance, his ability to predict what will happen. He has lost a family which, nurturing or not, helped him to try to define himself.

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Loss, separation and working through

Every adult human being has had the experience of coping with the serious illness or death of a person close to him. Many have lived through sudden and major changes in their jobs, families, hopes, and plans. Behavioral scientists (Freud, 1957, p. 126; Lindemann, 1961, p. 17) have studied the reactions of people to traumatic situations involving a loss of a meaningful person, of status, or of health. They suggest that reactions tend to follow a pattern. To themselves at least, people at first cannot believe what has happened. They may know it intellectually but have trouble accepting the fact emotionally. They deny it. Following this temporary state, people tend to withdraw into themselves, to question what they did to cause the situation, to question their self-worth; often they become restless, feel purposeless and helpless. In time, this phase diminishes in intensity and people begin to think about and talk over and over what happened. They are doing what the behavioral scientists call "working it through." Eventually, they become somewhat adjusted to the new situation, use less energy in self blame and in repetition and begin to address themselves to what they must do to fill their many responsibilities.

In most instances, adults have had sufficient maturing experiences to give them strength to get to the phase where they can talk out, work through their feelings of loss and adjust to the altered state of their lives. Theorists term these phases of coping, "the grieving process." Children, on the other hand, have had less experience in dealing with their feelings by talking them out. Scientists (Rochlin, 1966, pp. 36-37; Bowlby, 1961, pp. 501-502) who have studied children afflicted with the loss of a meaningful person, note that children react, that is, they know there is a change but they do not talk about it. They do not appear to become depressed. In fact, often they appear not to notice that anything has changed. They change the subject when people attempt to discuss the situation; they become very busy, active, or preoccupied. At times, they become physically ill, refuse to attend school, or become extremely angry with little or no provocation. In general, Rochlin and Bowlby believe that children, and emotionally immature adults, have difficulty in working through loss by talking about it. Instead, they act out their confusion and hurt. The behaviors we see are expressions of the inner stress they cannot put into words. The foster child in his new home is attempting to handle his feelings about his lost home and family, about lost relationships he had or hoped for. He does not know that he is struggling with loss and that sharing the process of adjustment might help. He knows only that he feels miserable, ashamed, angry, and alone.

Tasks of the child in placement

Separation. Placement in foster care poses a series of psychological tasks for a child (Kadushin, 1974, pp. 425-426; Littner, 1956, pp. 121-140). Both the anticipation of change and the move itself stir up painful feelings. The child has to live with separation from a known. This repertoire of experience with adults may have been limited or negative; his expectations of his foster parents will parallel that to which he has been exposed. If his new family convinces him that they care about him and that life may be less fraught with tension, he then has to adjust his feelings about these people, and about himself as a worthy and a loyal person.

The uniqueness of each youngster is evidenced clearly in the manner with which he handles separation. Foster parents describe a wide range of actions and reactions which they recognize are related to many variables. The child's ability to cope or the facets of his coping depend upon his age, length, and nature of his relationship with his own family, upon his ability to understand what is happening and upon the availability of help and supports for him as he makes the transition. In some instances, youngsters' families are involved in a positive manner; social agencies and workers may play a significant role in alleviating the stress; foster parents are aware of the child's vulnerability at this time. Regardless of the supports, however, the child suffers a pervasive sense of discomfort and strong, unconscious feelings. He has a haunting, rarely articulated fear that he will be abandoned. He wonders if his parents will ever want him back and what he did to cause them to be unable to love and care for him. With all the fear of rejection, he wonders what will happen to his home and people while he is not there. Believing himself unwanted, he feels helpless and worthless or scared. Thoughts such as these often precipitate the foster child's running away or wanting to run, usually back to what he left to test his memory, reception, and role and to look for evidences of hope or change.

The newly placed foster child is angry. He cannot accept the idea that he has no control over the move. Rather than settle for his lack of control, he seeks some semblance of autonomy in fantasy by seeing himself as "bad." This self blame gives him a role and also helps him to deny his real anger toward his parents. The anger and hostility trouble him in other ways, such as fleeting thoughts or hope that his parents will be hurt or punished for having rejected him. He then has to cope with those ideas and fears retribution for hating his parents. After all, he lives in a society which extols the virtues of parenthood and conveys the message that children should honor their parents. Such feelings do not go away; they appear in another form. Foster parents have found that children who do get over this stage of protest can also, with help, tell of having had day dreams about becoming very sick or hurt with the hope that their biological parents will feel compassion and seek reconciliation.

These are a few of the many frightening feelings which beset foster children who have suffered trauma in their families and a move into temporary care. The internal struggle threatens to engulf them. It is so much to handle that children often withdraw emotionally. They may anesthetize themselves against all feelings and become remote or withdrawn, inaccessible to foster parents and foster siblings. They appear merely to be going through the motions of doing things.

Feelings Toward the Foster Parent. Out of their compassion and experience, foster parents are often very sensitive to the new foster child's fears of the unknown. They recognize the need at this critical time for creativity in communicating their interest without fussing or regaling a child with words. They have learned to understand and expect the youngster's fear and his need to be accepted on his terms. A child who is tense, anxious, hungry for love, yet suspicious of closeness, may be frightened by an effusive welcome or display of feelings. He needs time to overcome the shock of a totally new situation. His self protection is to protest loudly or by sullen withdrawal. In either instance, he is limiting the number of messages he wishes to receive. Foster parents have found it prudent to create an atmosphere of quiet caring, to convey respect for the child's underlying struggle, and to give indication of their availability and willingness to understand at this time as well as when he is ready to communicate in a different mode. They find that to value what the child brings with him, his possessions, symbolically lets him know that they value him. Their conduct convinces the child that he will not be reprimanded for his anger and they want to help him through the pain. Pre-placement visits give recognition to the phases of the child's separation process. Opportunity for the foster family and social worker to share observations about the child's reactions and stages of acceptance may assist in strengthening the child's milieu. The foster child senses the need, foster parents and workers appreciate the wisdom behind the caution, "Make haste slowly."

In spite of the potentially disruptive, unsettling behavior noted above, it is easier for the foster child to handle his hostile, negative feelings than it is for him to cope with the emergence of positive feelings toward his foster parents. The disguises for his anger are relatively transparent. Internal havoc is wrought, however, when he first senses that his new family genuinely values and loves him and his disguises become much more subtle. Following a period of relative calm and apparent adjustment in his new home, the foster child may begin to react to warmth and affection with anger, scoffing, bravado, and foul words. He accepted intellectually the home, the people, and his place therein. To remain at that level would render him tractable, possibly conforming, much like a detached boarder rather than a labile, sensitive developing human being, still in need of nurturing. For real growth to take place, the child must adjust emotionally, that is with both his head and his heart. But the latter task is superimposed upon a person who has felt rejected at least once and has harbored a sense of worthlessness, of being unlovable. He wanted to be loved before, by his own family; he may even have felt some closeness that preceded ejection. To let himself accept and give love at this time may result in another rebuff or loss. If he acknowledges or takes his feelings out of the limbo to which he has relegated them, he will have to face his repressed anger toward his own parents and the fear that he will be hurt again. Further, in the all or nothing world of childhood, there lurks the danger that loving or loyalty to his foster parents implies disloyalty to former foster parents or to his own parents. The struggle is internal and solitary; the tenor of the behavioral communication, however, gives indication of the changing dimensions of the process.

Coping Behaviors. Until a child learns new methods of coping, he will rely on his established patterns. If he has had to learn to get along by fighting, he will probably use fighting as his defense in any new situation. He will seek to define his environment in terms with which he is familiar and will set up communication to elicit a known response. In the child's mind, foster parents will either be like or totally different from his own parents. He needs to find out which. Without conscious intention to do so, the child attempts to bring about a reaction he fears, one such as he received from his own parents. If his parents have had little sensitivity to his feelings and needs, or if they punished overly stringently out of their anger rather than commensurate with his behavior, the foster child will behave so as to test the foster parents under like circumstances. Should their reaction be the same as or similar to that of his parents, he will decide that parents are all alike and will be of no help to him.

All children, all persons, constantly scan the world of people for feedback; in new situations they assess repeatedly how they are perceived, whether or not they are accepted, whether or not they can trust others. The need to trust is pervasive; the belief that one can trust is established only after a series of encounters have limned an internal picture of consistency, logic, fairness, and strength. There is no reason to believe that the child in transition can accomplish this task any more quickly than can others in more stable, predictable situations. Trust has to be built, but the process for the foster child has some distinct patterns.

For many of the reasons mentioned earlier, the foster child seeks to keep an emotional distance. He hurts first, lest he be hurt. Acceptance of his nastiness provides an outlet for his cumulative anger and does offer a safety valve. He is bruised emotionally and must protect his feelings from further battering. To push away foster parents and keep them off balance may prevent their investment of time and caring, hence prevent his becoming close to people who belong to him only temporarily.

As most adults will attest, it is difficult to grow up, even under optimal conditions. The foster child, at least during the period of separation and transition, is a victim of additional pressures from waves of feelings that would be a problem for an emotionally mature person to handle. Relatively secure individuals are temporarily upset by major changes. With the adjustments demanded by moving to foster care after one or a series of family traumas, foster children have reason to "bottle up" their needs for emotional closeness and to become increasingly anxious about moving from foster home to foster home even after an adjustment has been made.

Implications

Literature and the experiences of parents, foster parents, foster children, and social workers suggest that a child moving into foster care suffers a loss which, because of his emotional immaturity, he is unable to handle by working it through. It is helpful for foster parents who have to handle what is going on on the outside — the child's actions — to know what is going on inside. The behaviors are surface signs of how the youngster is trying to come to terms with the inner turmoil created by his several losses. Every foster parent faces this task repeatedly because every foster child goes through the same process in some way or another. There are understandable feelings inside (anger, self blame, diminished self worth, fear of closeness, yet longing for love) and a predictable process of denial, withdrawal, testing, repetition of the same behavioral tests seeking congruence, and some relative calm followed by a hiatus in feeling, before a real adjustment with acceptance and a genuine healing experience can begin. The foster parents who are aware of these feelings and phases still find each child unique, but each situation not a totally new experience or an uncharted area. They have supports somewhat like a map and can pause periodically to find out where the child is and where they are in the early part of their journey together. The resulting security may free them to marvel at the consistency and individuality of every youngster as he finds his way through his personal turmoil. Their security may release the foster parents' energy to be directed toward increased empathic response and sensitive communication with the foster child. They need not be distracted by having to assess all the details of each situation anew. Instead, their alertness to key variables in the child's coping with each phase provides sufficient guides for their own actions. Their attention can be directed to finding the opportune time to comfort by quiet or controls and, later, for their attempts to help the foster child put his feelings into words.

No service to people has greater potential for travail; no work demands more sensitivity and caring. However, no work offers greater rewards than seeing children become happier, relatively more secure human beings, who have matured through the process of separation and adjustment.

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What the Separation Process Means to the Foster Care Worker

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In foster care, separation from meaningful objects, the accompanying feelings of loss, and the need for working through the loss constitute the major dynamics involved for child, parents, and foster parents. Sensitivity to and respect for the complexities of a child's reaction to foster placement, coupled with an understanding of the meaning of objects in human development and the process of handling loss, can greatly enhance a social worker's practice skills.

Temporary foster family care is a remedial or holding service offered by both public and voluntary agencies through the cooperation of families interested in housing and nurturing children who are not biologically their own. The families are known to the agencies through an application and home study process. Their interests, preferences, and specific capacities become more precisely defined as agency and family share the responsibilities for rearing children whose developmental needs cannot be provided by their own families. The foster care worker is a critical variable in the process that brings together strangers who must live with, relate to, and develop some mutually satisfying growth-producing experiences. Whether the worker serves as supervisor, consultant, coordinator of services, or in direct contact with child, parents, and foster parents, he or she often must work within structural, time, and legal constraints and deal constantly with complex interpersonal communication on several levels.

Of the approximately 300,000 children in foster care in the United States, 85 percent (Kadushin, 1974, p. 401) are under the supervision of public agencies. By definition and legislative mandate, corroborated by statistics, public agencies offer a broader range of services, handle a larger volume of referrals and emergencies than do the voluntary agencies. This may limit the scope of their service function. Public agencies work within defined legal parameters, with closely scrutinized budgets and constant need to interpret their actions to the supporting taxpayers. The turnover of employees is so large (Kadushin, 1974, p. 712) and the position specification such that they attract the young worker who has had little or no professional education. Even with the best of in-service training, it is difficult for the new worker to move into situations as complex as foster care where he or she must work sensitively with a child who has suffered emotional and often physical trauma, with the child's hurt, confused, angry parents, and with the foster parents as they evolve a way to help the child to deal with his feelings of loss and resume his or her emotional and intellectual development.

In public agencies, case loads tend to be large and the majority of children in foster care today are disturbed emotionally (Kadushin, 1974, p. 463). Wasserman (1970, p. 96) describes the child welfare worker as "often overwhelmed by the cumulative impact, perhaps by the cumulative terror of suffering, deprivation, disorder, ignorance, hostility, and cruelty he must face as part of his everyday work situation." Further, in foster care workers are beset by unique tensions (Littner, 1957). Workers are exposed to the hazard of having to handle their own unresolved problems stirred up by the intensity of the situations with which they are involved. Even the most well-adjusted, mature worker can be made tense by repeated and sustained exposure to a child's anxiety. People's feelings in general have a contagious effect. Specific feelings in a client, such as love, hate, dependency, anger, sexuality, whether articulated or not, can awaken similar feelings in the worker. The various kinds of separations, and often aborted handling of these, threaten anyone who has had trouble with his or her own life adjustment. Worker objectivity is often difficult to maintain, particularly in relation to the child's biological parents, often seemingly inadequate people. Contact with them may also reactivate painful feelings about deficiencies in the worker's own family. An almost universal compassion for children can also mask an unconscious need to play God-and-mother-and-father to the foster child, resulting in concomitant problems in sharing responsibility with other workers and foster parents. Daily emergencies, human frailty, unforeseen impediments, and the cumulative fatigue from constant tension frequently cause workers to question their own adequacy. They may lose perspective and be diverted from the core problems and issues by a plethora of details.

Because, as planners, transitional objects, and enablers, they provide a vital force in promoting remediation, there is a burden on workers to know themselves in order to become aware of how they respond affectively to their clients. Self understanding is difficult under the most felicitous of circumstances. The multi-faceted tasks of the foster care worker rarely offer situations tailored to the worker's stage of developing maturity and practice wisdom. Each child-family-foster family constellation is complex and, especially to the new, young workers, appears to be vitally different from all others. It takes years and experience to develop knowledge, perspective, resiliency, and some comfort with the role of intervenor into so many systems. The process of acquiring practice skill is made up of cumulative learnings and feelings from which the worker, consciously or not, develops a frame of reference for organizing, with some predictive potential, data about individuals and situations. Skill development may be enhanced by theoretical formulations which offer a relatively economical and comprehensible beginning structure for viewing information against defined, key behavioral variables. Theories of object relations and those describing the grief process following object loss are particularly pertinent for and helpful to the foster care worker. They suggest a way of clustering and conceptualizing significant behavioral dynamics as well as give clues to the appropriate level and kind of intervention which will be most effective.

Theories: Object relations and the grief process

Object Relations. Theorists differ on the specifics of the operation of object relations as vital to human development, but all agree that an individual evolves from his interaction with meaningful objects. Different theoretical orientations produce different perspectives. Fairbairn, as noted by Guntrip (1961, p. 288), suggests that the individual seeks objects that give him pleasure. Bowlby (1960, p. 9) believes the child becomes attached to his mother by the activation of a number of response systems which, if interrupted, give rise to other responses seeking to reestablish the relationship. Rochlin (1961, p. 454) notes that a child is dependent upon an object for his relief from tension, thus upon an object for maturation. He adds that without this object the young child does not survive and, if deprived of adequate object relationships later, the child's maturation will suffer.

Briefly, the maternal object reacts to and satisfies, in various degrees, the child's and her own emotional needs (Erikson, 1950, p. 231). Both need and find fulfillment through the process when it proceeds without severe impediments. The child who develops at all, that is, does not remain locked in primary autistic misery, finds comfort and stimulation. At first he cannot differentiate himself from his parents; gradually he sees them as separate objects and comes to recognize the parents as objects who satisfy his needs. He is thus dependent upon these parental or need-satisfying objects and threatened or anxious when they are absent. When he begins to walk and stretch his horizons, he is dependent upon the same objects for cues to his behavior. From the reactions of these very meaningful, molding objects, he begins to develop a sense of self with autonomy and security as much related to the characteristics of his interaction with "his objects" as to his genetic inheritance and temperament. For more thorough consideration of the specifics of object relations, see Spitz (1965), Mahler (1975) and Jacobson (1964).

Important to an individual's maturation is the quality of nurturing he receives from birth through adolescence. The maternal object satisfies the young child's emotional needs and induces him to inhibit, control, delay, and direct his energies. As he grows, characteristics of his needs for satisfaction change; he still, however, is dependent upon a continuity of nurturance. Changes in his living situation threaten to disrupt the continuity, the known, and add an additional task for him to face. The child with a history of satisfactory relationships is emotionally stronger than the child whose parenting and nurturing have been erratic and hostile. The feelings of the well-nurtured child are more likely to be accessible than the feelings of the emotionally scared child. The latter has built a protective covering which takes many forms, and foster placement gives him another set of feelings to disguise.

Essentially, it is helpful for the foster care worker to keep in mind that the human being evolves from his or her interaction with objects. Since object relations facilitate growth, any disturbances in an established, hoped for relationship are likely to have some effect on the person's developmental process. The effect differs in relation to the nature of the interference and the chronological and emotional age of the child at the time of the interference. Object loss is potentially disturbing to an object relationship. The child going into, or from one to another, foster placement suffers an object loss. The child is forced to leave a relationship which may have been desired or satisfying. Even if, in the eyes of the observer, the parent or surrogate nurturing has been less than ideal, it was a known to the child; it had some elements of hope and some meaning to both the child and his family. The separation involves a change in relationship, constitutes a loss and must be dealt with emotionally by the child and his family. Because it is so emotionally laden, the process is often disguised, delayed, or pathologically diverted. Until it is worked through, the individuals are not psychologically free to invest in other interactions with growth producing and satisfying potential. The perception and role of workers are vital links in the chain of psychic events precipitated by foster placement.

The Grief Process. Theorists studying persons who have incurred loss through death or separation suggest that there are distinct phases to mourning or grief. There is a process through which one goes that results in a change in the emotional investment in the object lost and an openness to the development of additional attachments. Lindemann (1961, pp. 7-21) studied adults who had suffered bereavement or separation from relatives and noted that the definite syndrome of acute grief has psychological and somatic symptomatology. It may appear immediately after a crisis; it may be delayed, exaggerated, apparently absent or distorted. Nonetheless, acute grief reactions proved remarkably uniform, having in common

(1) sensations of somatic distress; (2) preoccupation with the image of the deceased; (3) guilt-searching of the time before death for evidence of failure to do right by the deceased; (4) irritability, anger, hostility toward friends — all feelings which are disturbing to the person having them; and (5) a restlessness, continual searching, and inability to maintain organized patterns of activity. Lindemann (1961, pp. 10-11) also found that "the duration of the grief reaction seems to depend upon the success with which a person does the 'grief work,' that is, achieves emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships." He noted that many people try to avoid the intense distress of the grieving experience. This denial creates a tension often expressed through illness, hyperactivity, or hostility and uses up a great deal of energy.

Theorists differ as to the manner in which children deal with loss; in general, however, they agree that children react to object loss. Psychoanalytically oriented writers, Anna Freud (1960), Deutsch (1937), Mahler (1960), and Rochlin (1966), stress the importance of the child's developmental level in relation to whether or not and the manner in which he may be expected to handle loss. The very young child can accept immediately a substitute object (1966, p. 19). The child who is uncertain of his separateness from the caretaker may suffer some delay in further differentiating himself. The child's tasks as defined by Erikson (1950, pp. 219-234) for each developmental stage may be disturbed and result in his regression to an earlier manner of coping. This may mean marked withdrawal from social interaction, physical illness, or unusually aggressive behavior (Rochlin, 1966, p. 59). Self esteem and ideal integration of the personality can suffer. To complicate things further, the separation into foster placement may not be the first or only major loss with which a child is faced. He may have had prior losses, unresolved at the time of placement, from emotional neglect or abandonment even while he was receiving reasonably adequate physical care. Hence, knowledge of the child's level of emotional development, the characteristics of his relationships, and his coping patterns are important in understanding and predicting his reactions and needs.

Regardless of the level of development and method of reacting to object loss, there are commonalities in children's reactions to foster placement. Littner (1956) found fear and anxiety in the children he studied and suggested that they were related to feelings of abandonment, anger toward parents, self blame, and fear of punishment. Fraiberg (1962, pp. 18-31) described the stages of behavior of latency age children separated from their parents as withdrawal, emotional neutrality, negative and hostile feelings toward parents or foster parents, ambivalence and, at the end of her effective therapy with them, establishment of affection and trust. Her experience suggests that it is possible for that age child to deal with loss, particularly in a milieu which assists him with the process.

In her study of the reactions of latency age foster children to object loss, Thomas (1967, pp. 179-180) adapted the phases of grief work as postulated by Bowlby, added a pre-protest phase, and described the process in terms of affects and behaviors somewhat as follows:

Phase	Affects	Behaviors
Pre-protest	-absent or extremely shallow; if present, minimal, in form of soberness or false happiness	-seems to reflect automatic social without emotional involvement -generally conforming
Protest	-anxiety -anger -helplessness -weeping	-thought and behavior directed toward lost object -expressed anger toward others and self -appeal for help and rejection of help -active effort to obtain and craving for lost object
Despair	-pain -depression -despair -hopelessness	-longing continues but active efforts to obtain lost object are given up -apathetic, few demands, actively disorganized, purposeless, restless -lack of goal direction and little capacity to initiate activity

Phase	Affects	Behaviors
Despair (continued)		-withdrawal from interaction is pronounced; a preoccupation with things not people; regression marked
Detachment	-hope -sense of mastery	-primary investment in lost person has been removed; some thought of the lost person but it is based in reality; new relationships sought -behavior reorganized, more purposeful; reality testing improved

As is readily discernible from these few examples, regardless of the stance of the theorist or the population observed, there are universal characteristics to the mourning or grief process. Working through the phases may be more or less traumatic. With knowledge about the feelings underlying the behaviors of child, parents, and foster parents as they react to their losses and seek to develop new patterns of coping, the foster care worker is frequently a pivotal person in the process. The worker recognizes that all members of the placement constellation will in one way or another — quietly, behaviorally, or with a person who can offer interest, understanding, patience, and consistency — need to work through their feelings about the changes in their lives. The simplicity of the steps delineated is deceptive; the variations of reactions are unlimited and are determined by the personalities and situations of the individuals involved, their history of adaptation and communication pattern, and the nature and duration of the separation.

Implications for workers' tasks

For everyone concerned, foster placement is fraught with potential hazards. It is logical then to laud the services which have been developed to shore up existing families or group arrangements which have potential object constancy. Frequently, however, foster care is the only feasible plan. Because placement means severance of ties, it hardly needs to be written that the number of placements should be kept to a minimum. Whether spaced over weeks, days, or hours, there are phases to the placement process. It may ease the workers' functional burdens for them to break the process into parts, organize the individual and situational dynamics in a manner which gives guidance to the nature and weighting of their tasks. The characteristics of the worker-client interaction and the worker role change considerably from the preparation for placement phase, to the transitional phase and may be quite different in intensity during the adjustment period and the time in placement when child and families have worked through some of their feelings about their relationships.

Preparation. Theories of object relations define developmental tasks critical to developing autonomy and a positive self image. The level of emotional maturity and the nature of past, present, and continuing material and psychological supports are two integral parts of the human equation with which the foster care worker is involved. The worker's goal is to assess each part in relation to each of his or her clients and use a range of intervention skills to seek or maintain as much balance as is possible during the turmoil of change. It is helpful for the worker to assess the emotional age of the child to be placed and of his parents. Observation of behaviors and referral history often divulge the characteristics of people's patterns in relating. The clinging or autonomous behaviors of a youngster are either age appropriate or not; a child's attitude toward children and adults suggests the quality of the nurturance he has received. His freedom to be himself, or its opposite, give clues to his attained level of autonomy and his readiness to take on other relationships. Marked aggression or withdrawal may alert the worker to the degree of his internal struggle with the fear and anger pervasive when placement is imminent. The child's response to tension provides another key variable in understanding the nature of his relatedness to family and others. If a youngster has suffered other major changes in his life, other losses such as death or long absence of a caretaker for whom he had or with whom he craved an attachment, or if he had been placed prior to the current plan, it is vital for the worker to understand the manner in which he denied or worked through his feelings. Some children spontaneously articulate their hurts. Fraiberg (1962, pp. 18-31) notes that more often, and particularly when the placement has been or must be precipitous, the worker must help the child to revive his buried affects and deal with the anger and fantasy about parents and placement, with his ambivalence, and with his fear about worthlessness and punishment.

The child's biological parents, biological adults, have developed characteristic ways of coping with stress. Their method of handling tension is eminently visible and a very important force in the process of placement of their child. Records, referral sources, and worker observation of their responses give a picture of their ego development, their autonomy and ability to give of themselves. Their needs to be nurtured, their hunger for attention, predict a set of behaviors toward their child in placement as well as their need for considerable individual attention and social supports. Whether or not the placement is an elective one, parents harbor questions about their worth and invariably are suffering either shame or guilt. The understanding, supportive, and enabling interventions of a worker at this time do much toward preserving and building upon the emerging stability that is often the basis for a reconstituted home and happier, more fulfilled people. Honesty, clarity and firmness of the worker while sharing the building of long and short range goals removes from the traumatic situation some of its potential destructiveness to parents who throughout their lives may have received little nurturance and recognition.

The foster parents and workers form a team in which each member holds a different responsibility. The worker and foster parents together, with details supplied by the agency, seek to anticipate the meaning to the foster home of the introduction of the particular new element into their balanced system. Their combined observations of the child prior to and during placement provide details and feedback which enhance potential understanding of and planning for the child. Together they weigh the interactions of the preplacement visits of child and parents. The sharing process is supportive to all partners who together may be able to anticipate potential points of tension. The worker is a link to agency and to special services such as psychiatric, medical, nutritional, and legal consultation.

Transition. Even with what appears to be thorough preparation — discussion of plans and feelings, preplacement visits, and sharing of reactions -- the actuality of the child's move into a foster home will bring a resurgence of everyone's feelings. Fears and hurts, seemingly in control, may erupt in unexpected areas. Anger and fear of abandonment take varied forms but take form they do. The worker, acting before and during placement as enabler, eliciter of feelings, and caring planner, at this time carries a sustaining responsibility. He or she is the one person whose milieu and role has remained stable. The worker's relationship carries a steadying potential and a caring pattern of helping each person think about and discuss feelings and reactions. Through the worker's interventions, the crisis of placement may result in the child's and parent's further mastery of heretofore "acted-out" feelings. The worker's knowledge of the grief process, as explicated by theorists noted above, give him or her some perspective on what may appear only as raw turmoil. The worker has a guide for what to help the child and family articulate and a cause for satisfaction when they begin to work through their feelings.

Placement. The first few weeks in placement are a critical time of adjustment for all concerned. Child and parents communicate their feelings constantly, usually nonverbally. Their behaviors suggest their internal struggle and the foster parents are the people most often involved with both sets of behaviors. They must read these and react to behaviors which occur in their home. Rarely is there opportunity for advance discussion with their workers about specifics of their handling. They are on their own in situations wherein every interaction is important to the adjustment and future of several people.

Foster parents deserve support from the agency which has entrusted them with the tremendous responsibility for human lives. If they are new foster parents they are fortified by corroboration of their thoughts and actions; if they are experienced foster parents they enjoy the recognition of their continuing interest and skill. There are potential satisfactions from seeing a happier child, but foster parents also enjoy recognition by and contact with other parts of their team.

In a study done by Stone (1969, p. 33), a questionnaire concerning foster homes closed in 1965 revealed that 40 percent of the respondents were "no longer interested." The researcher speculated that the amount of satisfaction received by foster parents (both monetary and psychological) may be a significant factor in foster parent withdrawal. The same study (p. 39) cited, among other significant problems of foster parents, the high turnover rate among agency staff, hence the lack of a continued relationship with a worker with its potential sharing of knowledge and observations; organization insecurity and poor opportunity for recognition were also suggested as conditions not conducive to maximizing foster parent potential.

To add to their sensitivity and compassion, foster parents often are challenged by and enjoy defining their perceptions and effectiveness. This sharing of experiences with line and office workers results in mutual growth, functional efficiency and overall satisfaction. The worker's availability, support, and recognition are of supreme importance as the foster parents adjust to their new family. The foster parents' attitudes toward the worker contribute to the worker's self image and role definition.

The equation composed of functional responsibilities changes considerably during the beginning of placement. The foster parents' role is increasingly active as the nurturer of the child. Their interaction with the foster child further defines the nature of their relationship. They become enabling objects through which the child, and often the child's parents, add to their self images. The worker's role alters to that of resource and support. By timing and actions, the worker shifts emphasis to the child-within-the-new-home constellation and separates himself or herself gradually from being the major object he or she may have become to the child during the transitional phase. Should the child-worker relationship have been significant in intensity, this change may constitute another object loss for both. Object relations theory describes successful separation from the prototype caretaker as a step in the maturation process crucial to the manner in which the human being will be able to deal with the many losses occurring throughout life. Whether or not scarring has resulted from the original separation from a parenting person, each subsequent object loss must be negotiated. It is incumbent on the social worker to make the process of a possible loss on top of a previous loss as healing and maturing as circumstances permit. Of significance is the manner in which the working through is done, that is, in accordance with the child's readiness. Denial, anger, fear, and psychic withdrawal are expectable in this adjustment as they are in other areas of life. Any child needs to be understood in his reactions, which may be unpleasant, unbridled, and disruptive indeed. The foster child needs help to think and talk about what is happening to him. Worker and foster parents can share the task of watching for the opportune moments to assist the child toward constructive channeling of his feeling-related behaviors. As the child moves through his protest and into the pain of the depression phase, the foster family, through sensitivity, consistency, and nurturance, further define their worth to him as objects of trust. At this time the worker's withdrawal from an exclusive relationship with the child into working with and through the foster family maximizes the momentum of the mourning process, hence promulgates the child's ego development.

Successful adjustment to his foster home following resolution of loss through temporary separation does not alter the child's need for his biological parents. Natural parents are a child's security, his culture, his roots to the past, and some suggestion for his possible future. By the time he reaches age six, he has developed some of his parents' ways of thinking and reacting. He feels like them and needs to feel like them to develop an identification and to belong. Should he be placed at a younger age, he still fantasizes about the heritage he needs to feel whole. The child has fantasies about the good and the bad in his parents and about the good and bad in himself as a part of their family. Upon separation following severe illness, turmoil, neglect or abuse, a child may bury deeply his feelings about his worth. Reaction to these feelings and to the tremendous energy investment in keeping them inside may result in outbursts or moodiness triggered by any number of innocent-appearing circumstances — school matriculation, illness, vacations, even parties or foster parent family visits, and some more obviously problematic situations, such as visits from or to natural parents. (For discussion of the dimensions of natural parent-foster parents relations see Littner (1971).) Inherent in foster placement is another loss — that of security in a previously defined self image. The foster child seeks to assess who he is by eliciting reactions, first from the worker and later from the foster family, as to how they view him. Almost beginning anew, he will define himself through the feedback he receives from persons surrounding him. If he is treated as valuable, he is likely to see himself as valuable. If he is handled with consistency, he is likely to develop consistency. If he is in a milieu where people can talk out their feelings or communicate them in a manner in which they are understood and respected, he may more readily come to terms with his own. Simultaneously, the foster child is dealing with a loss of meaningful objects and with his own, very much related self image. Before he can resume his process toward maturity, before temporary care can develop from holding to remedial and growth promoting action, the child must become engaged in the process. Without this involvment, he may remain frozen in fear of all relationships.

Recent studies by Thomas (1967) and Walker (1971) of the foster placement process strongly suggest that problems in adjustment of the foster child persist and the child is hampered in his emotional and social development when there is an impediment to his working through his losses. Workers' knowledge and skill, coupled with the sensitivity, stability, and wisdom of foster parents, are important variables in helping to remove the impediments to dealing with loss. With theories of object relations and mourning as guides for organizing data, the more this service team can work together in balancing and sharing knowledge, support, and functions, the stronger and more economical temporary placement service to children will become.

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Caseload Management in Local Departments of Social Services

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The purpose of this article is to explore a general framework for the management of caseloads in local departments of social services. Although caseloads are basic units for assigning responsibilities to direct service workers, their actual management is a practical art which is strongly influenced by local conditions and related practices of general management. Since this is so, new or improved ways of managing caseloads are likely to gain acceptance only in the light of differential experiences with overall agency operations. A recent impetus for modifying local practices of general management is provided by Title XX of the Amended Social Security Act. Its major provisions clearly emphasize the importance of improved management and a clarification of principal agency functions, both of which are very closely tied to the management of service caseloads. Positive response to these new directives requires considerable initiatives on the local level, and the purpose here is to facilitate such response.

Prospects and obstacles

The practical implications of Title XX will have to be worked out in the long run on the basis of two fundamental notions. One of these is a general mandate to search more systematically for the most appropriate functions of local departments of social services: what is it that county agencies can do best and how could some of the things that they are now doing be delegated to or shared with other organized resources on the local level? The other idea is that the answers to these questions are to be sought through an improved management of services, i.e., formal efforts to account for what is being done and to what effect. Realistic participation in trying to meet these expectations assumes both an ability and willingness to change some of the present attitudes and practices of all involved. To put it precisely, supervisory personnel in local agencies may be expected to become competent caseload managers without losing any of their virtues as case supervisors. For that to happen, it is necessary to understand and appreciate a number of related ideas and practical concerns.

Management is only one of the major functions which has to be performed in local departments of social services--it cannot provide all of the answers. The view appears to be well founded indeed that increased management expertise alone will not solve the problems of what is known in some quarters as the welfare mess (Abels, 1973, pp.13-15). While the Title XX provisions of the Amended Social Security Act require a balancing of service development concerns with sound fiscal management, the development of an appropriate management technology is an important part of the general and largely unresolved problem of social services on all levels.

Although improved management skills can provide only part of the answer on federal, state, and local levels, their development requires a relatively high degree of control capability which is very difficult to achieve in social welfare. Rational management techniques presuppose the knowledge of and access to all practically significant factors of service delivery which affect program effectiveness and might militate against measures of efficiency based upon purely fiscal considerations. The inherent logic of the performance-effectiveness-efficiency sequence tends to place relatively severe burdens on the local level where technical expertise is least likely to be found. Whether and how "technical assistance" from above is forthcoming appears to be a significant part of the problem for local managers.

Inasmuch as caseload management is only a part of general management on the local level, its development will encounter several obstacles. First, overall management practices are closely tied to the satisfaction of systemic requirements in addition to the needs of the local agency's operations. Compliance with often detailed, federal and state "needs-to-know," whose significance is often unclear, tends to tax management resources rather heavily on local levels.

Stresses upon personnel who are routinely expected to perform the dual roles of supervisor-worker in many of the smaller departments of social services can be quite severe and counterproductive from the point of view of local operations. Second, the development and systematic use of mechanisms intended to generate locally relevant information for management require extra investments of time and energy. This is equally true of attempts to meet local "needs-to-know" with or without making use of at least some of the federal-state data which must be collected and reported. Finally, field reports about the lack of incentives for making such extra efforts are just too numerous to dismiss as unreliable. Nor can they be credited, however, with being exclusively "political" in the conspirational sense of that word, even though frequent and/or unexplained changes in rules and regulations might tempt some workers to attribute obscure political explanations to forces which seem to be shaping their daily work.

The brighter side of the coin is, on the other hand, that there is a more explicit interest in, and some willingness to face management problems throughout the entire system of social services. It bears repeating, however, that any optimistic approaches to the provisions of Title XX must consider the limited or partial role which management expertise can play in the improvement of overall social service problems. A brief discussion of basic management functions might further clarify this point and prepare the way for considering the more specific issues of caseload management.

Basic management functions

In a general way, it is both convenient and useful to divide responsibilities in all organizations into executive, managerial, and worker functions (Parsons, 1960, pp.59-96). Although in smaller departments of social services some of these responsibilities may overlap, those who are expected to perform multiple roles usually know in which capacity they are functioning at any given time. That such multiple roles may be quite stress-producing and counterproductive has already been mentioned. Both the developmental and accountability requirements of Title XX might practically terminate such undesirable arrangements through the eventual loss of programs and related funds to some other public or private service organizations.

The technical core of executive responsibilities consists of efforts to legitimate the programmatic mission of the agency. Social service programs cannot come into being and remain viable unless the agency has the moral authority (mandate) and related supports (funds, clients, cooperation, etc.) from the community at large. Legitimating authorities and necessary supports can, of course, be of many kinds and well beyond the various levels of local authorities. The complexity of their functions may provide quite credible explanations for the periodic absences of executives from the agency and for the general character of program directives which might be handed down by them to equally busy managers. Executives are expected to divide their time and energies between participation in the making of basic policies and in the transformation of them into agency policies.

The extent to which executives participate in the specification of basic social policies for direct operational purposes tends to depend upon their available time and executive style. Some executives are more inclined to involve themselves in the performance of general management functions than others. General management functions refer to policy specification through decisions about how resources are to be procured and used in the pursuit of program objectives. Policies are specified through management decisions for operational purposes. The resulting rules and regulations provide a framework for internal procedures as well as service performance in the field.

Within the logic of this conceptual scheme--a "tight ship" model which public social service organizations are widely expected to approximate--the general function of workers is policy implementation through services to clients. The underlying assumption is that properly developed organizational arrangements will enable workers to do their professional best for clients. The fact that the professionalism of workers and client expectations may represent two general orientations which are more or less independent of organizational purposes is just another problem--for management. The general importance of this point derives from the fact that the Title XX provisions that combine developmental concerns with accountability requirements tend to impose added burdens upon managers, and some of those burdens will have to be shared between managers and workers.

The fundamental technical problem is that rational management systems are mechanisms of decision-making, and they are greedy for facts. In organized social services, the all important facts of management have to be obtained through a formal monitoring of service performance by workers. This is a difficult thing to do, especially if a significant number of workers believe that their efforts might be subverted for organizational or political ends rather than improving the lot of clients and/or workers.

Intelligent cooperation by workers is necessary for retrieving the basic facts of service delivery, without which there is no way of accounting for program effectiveness and efficiency. By the same token, rational attempts to develop an emerging and fragmented field of concern such as "adult services" into a coordinated field of organized services require service-generated data and analytical management capability on local levels (Estes, 1973, pp.178-183). How caseload management fits into the dual perspectives of service system development and accountability is the problem to be considered here.

Toward caseload management

Local departments of social services "manage" to do many things and may even do them well. The question of how well they do them may be raised, however, by at least two significant groups: official representatives of the public at large, and clients. Both may raise questions of accountability. To "account," of course, is to render count of particular transactions and events to those who have a right to know.

Improved management of social services begins by keeping count of events and transactions within and outside the agency in which service activities take place. If one identifies and counts tasks which need to be performed for helping people, a sequence of tasks may eventually be recognized as a practically significant process of service. Several processes may, in turn, account for all transactions and events of a service program, and several service programs constitute the justification for the existence of the social services department itself. All of these can be identified, counted, and compared for purposes of arriving at reasonable judgments about their relative value--with or without concentrating only on their cost effectiveness. While some tasks may be worth doing, even if badly and at great cost, others may not be worth doing at all. The important point, however, is that no rationally informed judgments can be made about the relative worth of service task, processes, and programs without some form of counting and comparing. As opposed to somehow "managing" to do what needs to be done, formal management of social services refers to this kind of counting and comparing, beginning with caseloads as basic management units.

Relatively recent efforts to introduce some counting and comparing into social services enable local departments to distinguish between such general "service events and transactions" as information only, case referral, and active service cases. It is now possible to count and compare, throughout several service programs, the relative number and frequency of such simple tasks of need assessment as merely providing information or referring applicants for service to some other providers. Some measure of cost (time, energy, money, etc.) can now be applied to these relatively simple events of assessment as opposed to what is generally regarded as the substance of agency operations, i.e., providing services for active cases which require a "diagnosis" and a step-by-step sequence of removing barriers to such general service goals as self-support, self-sufficiency, prevention-protection, community-based care, and institutional care. Management of caseloads begins by assigning specific criteria to the tasks and processes involved in the removal of various barriers, i.e., the technical core of doing casework. The fact that any attempt to interpret and to understand properly tabulated results of counting events and transactions raises more questions than it provides answers, constitutes the central promise of rational management techniques. It is by trying to extract meaning from the data of on-going service experience that one can hope for successfully improving agency routines, engaging in necessary developmental work, or devising service plans from year to year.

Inasmuch as "authorized services" represent the "technology" of barrier removal, overall program performance depends upon the number and quality of authorized services. The resource bases of authorized services are to be found in the more or less limited world of the clients' own community, in the service agency itself, and among the other service providers within the county. Since the work intensive mobilization of the clients' own resources is an agency function, it is more useful to distinguish between in-house, outside-no-cost, and outside-purchased services. These general types of services provide an analytical framework for the identification of management objectives in terms of improvement, development, and planning. The improvement of established in-house functions may be sought through in-service training, a modification of service routines, or the reorganization of job assignments. Developmental work, in turn, refers to either the creation of new resources or the formal linking of already existing resources in and outside the local department of social services. Specific objectives of improvement and developmental efforts constitute the substance of annual service plans.

Implications for agency policy

Only a general outline of the potential results of improved management efforts has been attempted here. The basic purpose remains to show how caseload management differs from the interests and hard-won skills of the case supervisor. To articulate that difference is neither an easy nor a particularly popular task. Perhaps the simplest way of attempting it is to say that the case supervisor is a natural ally of the worker because their mutual interests tend to center upon the best possible handling of the case. The caseload manager's interests, on the other hand, tend to focus upon the best possible handling of all cases which are active within a specific service program as part of the general mission of a local department. Although the fine points of this distinction can easily lead to lively arguments, the basic difference between the two orientations is quite clear. It is one thing to know a lot about the unmet and unsatisfactorily met needs of individual clients, which tend to preoccupy workers and case supervisors, and it is another to know how such needs of large client groups can better be met through the modification of service programs--which is the central problem of management. Transition from one role orientation to the other requires the mastery of new skills and release from other important duties in order to perform new ones. A mere "retooling" of case supervisors is bound to have limited results unless the performance of management functions is recognized by making carefully protected new assignments.

Special attention to the assignments of those who are expected to combine the complementary roles of case supervision and management is warranted by a genuine need of social service systems. Within the corporate context of organized social services, the need itself stems from the dual requirement of accounting to both "higher-ups" and clients. While accountability requirements may be viewed from either perspective, it is exactly the tension between social and individual responsibilities that has to be managed--which requires an understanding of the general mission of social services. Social services are generally expected to accomplish two things. They are expected to facilitate the access of the "disadvantaged" to those functional human services (education, employment, health care, etc.) with the help of which the "average citizen" is able to take care of himself. Or, the social services are expected to maintain those, above a level of mere subsistence, who cannot make effective use of the basic services which are generally available to all (Wedemeyer, 1970, pp.9-25). The way by which either of these missions can productively be accomplished and accounted for tends to favor the knowledge and experience of those who are actively engaged in this special kind of "production." Caseload management by managerially "retooled" case supervisors aims to do exactly that. It is based on the assumption that supervisory and managerial skills are not antithetical but complementary, and their joint development will meet a very basic need in organized social services.

The basic justification for creating and/or protecting management positions in local departments of social services is the fact that the identification, collection, processing, and analysis of program performance data is seldom compatible with other time-consuming assignments. Whether technical assistance from "above" for meeting management needs on local levels can effectively facilitate the creation and/or protection of such positions is hard to say. It is considerably more clear, however, that none of the newly articulated promises of Title XX, and other standing commitments can successfully be fulfilled by "fiat from above." Such, by now almost traditional, management objectives as improved program performance (elimination of fraud, worker error, etc.), the development of coordinated service networks, and effective planning, are very difficult to honor without significant inputs by local management. Finally, local conditions (topography, settlement patterns, socio-economic development, etc.) may set serious limits even to an adequate management technology which by itself cannot compensate for the other shortcomings of a service system. For example, agency data may strongly militate against the retention of information and referral functions for certain programs, but no substitute information and referral service can be established within the county. Similarly, transfer of entire programs and service referrals as partial program components, at no costs or on a purchase basis, may be impossible because the community lacks alternate providers. Under these conditions, caseload management will require a rather sophisticated calculus of resource allocation because of the necessary trade-offs between meeting service needs and all other requirements of overall agency performance.

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Roles, Patterns, and Process in Supervision

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Part I — Overview

The material in this paper is presented with tremendous respect for protective service supervisors who are responsible for many frequently inexperienced workers dealing with very complex situations that have long term implications for all of the persons and services involved. It is divided into two parts. Part I presents a few key concepts in the learning-teaching transaction and is geared toward immediate usefulness for practice. The focus of Part II is on solving problems in practice in a manner which will enhance workers' knowledge and further assist their developing practice skills. Illustrations, for the most part, are from actual, but disguised child abuse/neglect practice situations.

Supervisory roles

Supervision, in a social service agency, is made up of a series of problem-solving activities shared by supervisor and worker. The problems may at one time pivot around tangible resources for clients, at another time around the knowledge and skills of the worker. In either instance, the supervisor serves as an administrative facilitator and as a teacher. Neither term conveys the fullness of the responsibilities that experienced supervisors know them to entail.

Often of most immediate consequence in case conduct are the facilitating aspects of the supervisor's position in the communication chain. The supervisor of several workers has sufficient distance, perspective, and numbers of cases within his or her purview to be able to spot trends in situational characteristics or geographical distribution and in specific or overall training needs and morale. An ever quickening pace, increasing staff frazzle, and the supervisor's assessment that people may be attending to minutiae while missing essentials suggest need for system assessment and possibly for a change in priorities. This classic condition is repeated on different levels with many variations on specifics; it is sufficient mainly to note that the supervisor is at the hub of this facet of administrative facilitation and can relay information to management.

In the administrative facilitator role, there are essential business aspects to agency administration. Service innovations and theoretical contributions must be assessed through reading professional literature and attending conferences.

An essential but often undervalued supervisory function is record keeping. Methods differ in accordance with agency demands and systems. In most instances, periodic written and shared evaluations of the performance of workers are an administrative requirement. Supervisors develop a system for keeping notes about each worker with some specificity beyond number of cases assigned and closed. In relation to their accountability to staff, many supervisors have found it prudent in honing their own teaching skills to note periodically the characteristics of their interactions with each worker, to indicate in writing the focus of their conferences, the particular learning need of the worker at that time, their method of assisting the worker, that is, the teaching technique used and the worker's response. This cumulative file provides an excellent history of individual learning-teaching patterns and a fine memory aid for the supervisor with a large staff. Undergirding this practice is the belief that the supervisor's educational assessment of workers' needs, the supervisor's teaching input and attitude are highly critical elements in worker growth, hence in agency efficiency and sophistication.

Maintaining distance and perspective can become a major problem to the supervisor, especially in handling inexperienced workers. It is the worker who goes to the home or the court, reacts for the agency, brings the image and touch of the agency to the client and the community. It is toward the worker that the client reacts. If the client believes he is understood (not necessarily that his behavior is condoned) he will view the agency as potentially helpful. The first opportunity to engage a client in the process which may eventually lead to increased satisfaction for him and his family rests with the line worker. This is a grave responsibility for even the most secure, mature, and experienced workers. When the worker is young and inexperienced, the supervisor's itch to get out into the field and to do the worker's job usually increases by geometric progression. Institutionally however, he or she is needed elsewhere and this very provision makes possible the greatest help for the greatest number of people. The supervisor is the adjunctive inner resource for several workers and ultimately for all of their clients. The supervisor helps the workers to sort out what they have seen and heard. In the relative emotional cool of the office where the worker is free from the actual encounter with abusing or neglecting parents, the supervisor joins the worker in assessing the effect on the client of his or her approach and presence. Together they can consider short and long range goals. Satisfactions are still available to the supervisor from knowing of happier, more productive clients, but the source of major fulfillment becomes the increasingly competent worker who can manage independently.

In the hectic, busy ambiance of most protective service offices, emergencies are routine and demands on supervisors for decisions and assignments are constant. Creating an island of relative calm for thoughtful, paced consideration of client situations is more a hope than a reality during many working days. Yet the supervisor must convey a sense of order and an atmosphere permissive enough to permit mistakes and foster open communication. At times the supervisor's function may entail dismissal of a worker or helping a worker to recognize his or her inability to perform in the particular service. Accordingly, the supervisor has power, or at least the authority, that goes with accountability. With an insecure worker, the power element is often magnified, more so if the supervisor's role has not been clearly defined. For this, among many other reasons, it is helpful to describe the entire supervisory process as a series of tasks shared by persons with defined, mandated functions. The process is facilitated by acknowledgement that there are emotional components to their interaction. As in any interaction, there are no absolute answers. A shared and open way of looking at any situation is the crux of communication and of problem solving.

In their teaching roles, supervisors have responsibility for conceptualizing and systematizing knowledge about human beings and about the methods of helping them in relation to the specifics of the clients' situations and the agency policies. Such knowledge has predictive potential when utilized by a professional worker who is aware of the theoretical weaknesses and who has developed some awareness of his own biases. On a foundation of understanding human interaction, theories of intervention and their various techniques provide supervisors with a reservoir from which to draw in their assessing and teaching endeavors. All of this knowledge would be sterile, however, without the wisdom and individual style which develop through testing, modifying, and testing again by practice. Therefore, sensitivity to both worker and client needs and knowledge of the particular characteristics of the agency client population are major elements in the practitioner-supervisor's value to service and workers. From the perspective of knowledge and practice wisdom, the supervisor directs the worker to the dynamics of each situation, teaches concepts which are transferable, and accepts the fact that he or she cannot and need not be responsible for every detail of every situation carried by each worker.

As supervisors know so well, each worker is unique. Each differs in age, abilities, attitudes, knowledge, commitment and energy. Each moves at a different pace and responds to different challenges. Some have had extensive volunteer experience and have always gravitated toward work with people. Others have relatively little service experience but a natural capacity for empathic understanding and an eagerness to help. The range also includes persons who could not afford or get into a graduate school and those who qualified and merely needed a job. Maturity is not necessarily related to chronological age, and life experiences may or may not prepare workers for sensitivity to the feelings of persons who are like or very different from themselves. Levels of intellectual ability and the quality of formal education are factors which may affect the learning process but not necessarily limit the workers' practice effectiveness. Knowing this, supervisors tailor assignments, production expectations, and teaching techniques to individual workers. The ultimate goal for all workers is growth toward practice independence.

In helping workers to think conceptually and to recognize patterns of action and reaction, it is important for supervisors to discuss their progress with them periodically. This joint assessment of short range goals initiates or reinforces a self monitoring process which contributes to practice growth and helps keep open communication between supervisor and worker. The supervisor is able to convey understanding that learning pace, depth, and integration differ even within the same worker. This in itself is supportive and precludes workers' fantasies about the excessive power and authority of supervisors.

Recognizing patterns

To beginning workers, each case appears to be completely new and confusing. Rarely do they spontaneously note the dynamic similarities to other cases and often get caught up by their own values. In a referred situation, the protective service supervisor needs very few behavioral clues to recognize a predictable client pattern.

As an obvious example, the supervisor knows that the underlying dynamics in abuse and in neglect situations are different. With the abusing parent, the salient feature is a presence of something; with the neglecting parent, it is the absence. From knowledge and experience, the supervisor recognizes that the presence of one of the features of abuse suggests the possibility that the constellation of behaviors will include a highly charged negative feeling toward one child which may be triggered easily by a specific type occurrence. The parent is struggling with an underlying rage of long standing and aggression which he has never been able to channel or control successfully. The parent's needs suggest areas for intervention and the pattern and nature of the abuse give clues as to the potential continuing danger to the abused child.

The dynamics underlying neglect also cluster, harboring predictive potential and treatment implications. Neglecting parents are emotional children themselves and have suffered insufficient or erratic nurturing; they do not trust relationships with any one since they have had no satisfactory prototype. Lest they be further hurt, they struggle to keep from feeling and are burdened with a core depression since they have never acknowledged, much less worked through, the loss of the longed for experience of being cared for. They have nothing to give but may use bravado to cover their internal emptiness and few real satisfactions.

Protective service workers armed with knowledge of these patterns have a transferable base. Through their own situation-specific data they will refine, become sensitive to mutations, and be freed to listen for the key behaviors as well as for those which differentiate one person from another. The worker's energy can more readily be used in focusing on the client rather than on his or her own discomfort.

Part II — The Supervisory Process

General principles

For purposes of economy, two basic working principles for supervision may be extracted from what we know about human beings and the learning process. In statement, each is deceptively simple; in practice each is incredibly complex with permutations which are functions of the countless client, worker, situation, and supervisor variables. The first: Divide the subject or problem for mastery into small, relevant tasks in accord with the worker's ability to handle the material and integrate them in an orderly progression. The second: Foster the worker's professional growth in the use of theoretical knowledge and emotional responsiveness simultaneously.

Protective service situations are replete with the tensions of expressed and unexpressed emotions. Workers long for knowledge, if only as a protection, for experience, for wisdom, for vision, and for skill. There is no way to impart all of these at once and the supervisor is faced with the task of helping to sort out what must come first, what is the major need or block to service for both the beginning and the experienced worker. The nature of the problems and impediments differ, but the principle of removing the clutter, setting priorities, and seeking to master one thing at a time still pertains. The hazard for a supervisor lies in flooding the worker with knowledge, explanations, or tasks which he or she cannot assimilate.

The new worker is likely to need the guidance gained from discussion of the facts available at referral, his or her reaction to these facts and speculation as to the client's attitudes. The supervisor supports the worker's personal responses to abusing or neglecting parents and views them as significant diagnostic data. The supervisor's selection of items for advance discussion serves as a subtle triggering and channeling device for the worker who might possibly be lost among the plethora of observable items in any complex home situation. The discussion focuses the problem, beginning where the worker is and building upon what he or she brings. The experienced worker frequently articulates a list of possible choices of action, but may require help in sorting out what might appear to be conflicting data, or wish to consider the client needs in relation to the apparent limitations of service available.

Supervisors and workers alike want to help and want to savor the satisfactions of having given or done something. The new worker, in particular, would like to have answers. Since there are not answers to most of the conundrums with which workers are faced, supervisors relieve new workers of a large burden if they can convey to them that the work is a process of doing and planning with a client rather than to and for him. If workers can see the absence of answers and quick solutions as an impetus to involving clients in plans which they may some day be able to implement themselves, they will have mastered one of the first principles of a helping profession. This mastery will be reinforced, and probably taught predominantly, by the supervisor's style. One of the most powerful sentences in supervision, teaching, and practice is: "Let us take a lock at this together; let us see if we can figure out how it got to be this way." Sharing the sorting out process advances workers' ability to cluster and organize material. It is an early step in the diagnostic process and permits discussion of interventions related to underlying dynamics.

Although it is difficult to disagree with these ideas in principle, supervisors are very busy and pulled in many directions. They often suggest that there is not sufficient time for such reflective interaction. They are undoubtedly correct in terms of the fullness of their days and their varied responsibilities. Such a condition suggests need for examination of the alternatives. If workers develop security, wisdom, and autonomy and clients do the same or at least improve, the agency system may be providing adequate support to guarantee quality service. At times, however, supervisors find they are answering the same questions related to different sets of data and increasingly getting caught up in individual case details. Such a situation highlights the wisdom and relative economy of increasing the emphasis on the teaching role.

Specific problems

A young, inexperienced worker's account of her home visit to Dale offers opportunity to reflect on the manner in which a supervisory session using the data, process described, and worker's questions might be utilized to foster the worker's professional growth in the use of theoretical knowledge and emotional responsiveness simultaneously.

> Dale is pregnant out of wedlock and was referred to protective services because of a daughter who frequently "wandered off"; man involved had lived with her briefly; at this time was living with his wife.

1) I had knocked on Dale's door earlier that afternoon, but received no answer. On my second visit, she opened the door and when she finally recognized me, told me that she hadn't remembered my name so she couldn't call me back before. I came in and introduced myself again, explaining who I was, where I was from and why I was there. I said that I was not a Welfare worker, but there to talk with her and help her with any problems she might have. I also explained about confidentiality.

2) She said she understood, but didn't have any problems. I asked her about Honey, since that was how Protective Services got involved in the first place. She said Honey was fine. She used to wander off, but doesn't any more. She goes to school and is fine. I then asked how she herself was doing. Fine she told me, except that she was tired and uncomfortable (due to her pregnancy). There were several pauses. Dale was very quiet as she continued sewing a pillow together. I asked her about those harrassing phone calls she had been receiving. She told me she put an end to those. She told the person she had had her phone tapped.

3) Since she said she had no problems I asked her if she was happy. She replied, "you're as happy as you want to be, right? Don't you think so?" I said I really didn't know the answer to that. She kept

moaning and said she couldn't wait for the baby to be born, probably around January. I asked how Honey felt about it. Dale said, Honey couldn't wait, that it would probably make a big difference. I asked in what way, and she said Honey would now have a brother or sister to play with, take care of, etc.

4) She then said that Mack said he would support the baby because it was his, but Dale doesn't care about that. She said that when the baby is born, Mack will have to decide on Dale or his wife. He can't have them both. At one time Mack moved in with Dale, but then went back to his wife.

5) Dale then began to ask me questions, such as how old I was. She said I was young so I probably didn't know, but asked if I was married or even in a similar situation. I tried to get back to her, but she kept asking about me. Did I live at home, was I ever involved with a married man? She told me she wasn't married and she knew some people would think that was bad but that was just the way it was. She said Mack's wife is only 20 ("She's young like you") and she has three kids and another on the way. Then Dale called her a bitch.

6) To get off the subject of me, I changed it back to Honey -- saying it was good that she was enjoying school. Then there was more silence as Dale kept sewing. She said she was really tired. I said that I would leave then and let her rest. She said she didn't want to be rude but she was going to take a nap before I came. I said it was fine, and that I would see her again next week. She said okay and walked to the door with me.

7) When she was questioning me, although it was just in a curious gossipy way, I felt very uncomfortable, mostly because I knew I shouldn't involve myself in the interview and because she was sidetracking me. She was making it out as a friendly conversation between two friends, and she wasn't allowing me to conduct the interview in a "business-like" relationship. I think this is because I was younger than she was, and she just didn't think I was capable. I could be projecting, but I felt it. It's also probable she just didn't trust me.

To the supervisor, Dale's behavior is eloquent; the dynamics are clear indeed. Dale is uncertain about her acceptance by the worker and is not ready to articulate problems directly but repeatedly talks about what is the underlying, pervasive reason for Honey's wandering. Dale is hungry for acceptance and nurturing; she has little to give. The situation brings to mind the constellation of feelings and behaviors common to neglecting parents and with it harbors predictive potential as well as clues for intervention. There is a knowledge base from which to draw, but it is obvious that the worker either does not have it or has not made the connection between it and her practice situation. Grossly evident also is the worker's discomfort, insecurity, lack of clarity about her role, tendency to interrogate and to move away from feeling content. The worker is uncertain about whether Dale or Honey is her client. She conveys concern about Honey when Dale is seeking the worker's view of her. There are sufficient classic actions and reactions in the situation to serve as the teaching vehicle of a supervisory conference session. The worker's understanding of even a few principles will affect her other work.

There are many specifics from which the supervisor might work. Knowledge about the way people learn gives opportunity for economy in selection and points to the wisdom of acknowledging the positives in the worker's action. The worker prepared a relatively full recording, far more eloquent than she believed it to be. Commendation for her recognition of her discomfort, and reinforcement for her attempted self and situation assessment might offer an appropriate prelude to discussion of the behavioral dynamics and her own emotional reactions to being rejected. Later it is possible to seek similar patterns in other cases carried by the same worker.

Importantly, learning by doing is a process that cannot be rushed. Alfred North Whitehead (1949), an educational philosopher, described the general phases of learning as: imaginative consideration, analysis, synthesis, generalization and imaginative reconsideration. Essentially, the supervisory process, which includes guidance, consideration of situation specifics, clustering behavioral dynamics and noting both client and worker patterns of action, followed by generalization to other cases, parallels the phases described by Whitehead.

It would be simple if this process demanded one nicely timed application per worker. Supervisors, however, are aware that emotional grasp is slower than intellectual awareness and that shared seeking for key variables has a triggering process which promotes the thrill of discovery in other contexts. A worker is enroute to relative efficiency and autonomy only after his or her learning becomes conceptual, transferable and spontaneous. Ralph Tyler (1950) suggested that all learning must have continuity and sequence before it can lead to integration. The burden is on the supervisor to be selective in attempts not to teach everything which the worker needs to know but to teach a few key elements thoroughly and trace and connect all ideas.

Some specific principles, areas of concern, learning differences

There are many opportunities within agencies to advance the knowledge and experiential facets of practice competence. Frequently the supervisor is instrumental in fostering group meetings, staff presentations, peer supervision, consultation, and changes in agency record keeping. The timing of a worker's presentation can be a critical factor in crystallizing his or her learning -- or anxiety. There are many commonalities among reactions of clients and workers toward each other which lend themselves to group discussion. Since they differ with the type service and experience of the workers, each supervisor might find it prudent, and ultimately economical, to note the repetition of questions from one worker or the similarity of learning needs among several workers and build a discussion agenda around these. There are expected universal occurrences such as: "can you really help me?" which is the real question behind inquiries about a worker's age; disguises for the client's need to know if the new worker views him as do other members of the community; the hidden and persistent testing to learn if the worker is strong enough for the client to lean on; workers' fears that clients will become dependent upon them; and the strength behind client "resistance" to intervention in his life. There is potential peer support in formal and informal topical discussions and a need for focus as well as an evaluation of the success or failure of the process.

In many respects the social work supervisory process evolved from a form of apprenticeship and is still fraught with some hazards because of this genealogy. The supervisor's goal is most enabling when it includes helping workers to handle situations in their own style, not necessarily exactly as would the supervisor. Workers may go through a phase of imitation before they have adequate knowledge and security about their roles. This should be recognized and positive reinforcement used when a worker ventures successfully into functioning openly in keeping with his or her personality. To maximize individualization and gear assignments to worker readiness, the supervisor becomes aware of the worker's patterns of relating well or poorly to clients of different ages; he or she observes the worker's functioning in relation to other values and cultures. Most importantly, the supervisor must be alert to what the worker does well or poorly by intuition or chance and must recognize the point at which intuition, self-awareness, and knowledge are fused into a useful interventive tool.

A very young worker's recording of his first case, Billy J., a 9-year-old boy in a residential treatment facility, illustrates many of the above motivation-personality theory based principles.

1) Billy walked in looking quite fit and immediately picked up a toy gun. He took aim and said, "I hate you and Mr. Johnson," and then "shot me." He then aimed through the wall and pretended he had killed Mr. Johnson in his office. I said, "it seems like you are angry at us." Billy said he wasn't and answered "I like to kill." I waited for a while and asked him why he was angry? He responded "I don't know." I added "maybe we did something you didn't like?" He did not answer and shrugged his shoulders.

2) He then pretended someone was knocking at the door. He opened the door and let an imaginary cop in and proceeded to direct the men to lean against the wall to be frisked. He told the cop to sit down and then shot him. I asked why he did this and he said, "I hate cops; they're all stupid flat feet." Another person knocked and it was the father of the cop. Billy shot him too. Finally the grandmother of the cop knocked and entered. Billy aimed at the grandmother but then put the gun down and said, "I

couldn't do it." I asked him why he spared the grandmother's life and he said, "because she is old and nice." I added that probably the mother and father were nice too. Billy shrugged.

3) He took the gun and showed me how big the gun's shadow was on the wall. He said, "look how big the gun is on the wall. I like guns." I said, "I bet you having a gun makes you feel strong" in a casual way. Billy closed his lips and faintly nodded in agreement.

When the supervisor read the recording he was thrilled with the process, the worker's apparent ability to relate to and help the boy recognize and talk about his feelings and even label the youngster's anger. Upon reflection, however, the supervisor realized that such conceptual and practice sophistication was unlikely in a worker without any professional education or experience. In planning for their supervisory conference, he hypothesized that the approach was probably spontaneous and intuitive. Accordingly, he handed the worker the record commenting, "This was really great." The worker looked surprised and said, "It was? What did I do?" The supervisor followed his explanation of noting and helping the youngster with his feelings with an inquiry about what the worker might have been thinking at the time and how he happened to react as he did. The worker replied that he likes kids who love their grandmas. Clearly, the worker's intuition worked that time but was not yet a skill based on knowledge, hence not a conscious or dependable tool. The supervisor and worker together had developed a definition of part of the learning-teaching tasks ahead of them.

Stimulus-response theories show that some overlearning and repetition are necessary. This does not mean "drill," but rather repetition which progresses through seeking out patterns, concepts, dynamics which are similar but appear very different in another situation. For example, workers' life experiences and natural empathy often help them to understand the stages in the process of working through the loss of a loved person by death. With prompting, they frequently transfer this knowledge for use in child foster or adoptive placement but invariably have problems in accepting the construct in relation to clients' losing them as workers. Even more problematic is their definition of what has been lost and what loss must be worked through by

persons who have a core depression because of the absence of adequate nurturing. The complexity of the relationship variables in situations with which they deal remains illusive for a long time.

Some workers master the skills of intervention relatively quickly and talk and act on principle easily. Supervisors have learned to be guarded about leaving workers on their own too soon; rather they are alerted to watch for genuine progress lest the worker's cognitive precocity mask an absence of affective involvement or empathic communication. Workers need recognition and support with each step to be able to see their own growth and increasing ability to take responsibility. A mere pat-on-the-back type general comment that everything is fine is of relatively little help in advancing precision in professional growth. Workers need to know what they did well and what might need continuing refinement. The shared process of supervisor and worker defining accomplishments and limited and long-range goals is an integral part of skill development.

Cognitive theories are replete with guides and supports for supervisors. The shared attempt to reconstruct and understand client to client interaction over time and client with worker interaction during interviews taps learned knowledge of the meaning of behavior. The process also delineates both client and worker patterns of handling feelings and triggers reasoning and hypotheses about causation and potential intervention techniques.

Supervisors have found it helpful to share with the worker in examining the beginning content of an interview seeking what the client seemed to want. This, juxtaposed with what the worker did, that is, how he heard and responded to the client's verbalized or behavioral request can be very revealing to a worker who is struggling to be sensitive to client's feelings and self aware.

The Sharon record illustrates the young worker's struggles, her desire to improve but her awkwardness in response to rebuffs, her attention to the child rather than the mother in a manner which might well convey the opposite of caring.

1) On Tuesday I visited Sharon Moore. Both her children were up and dressed, and were playing in

the living room. I noticed that both Joseph and Ellie seemed alert and didn't have colds any more. I commented to Sharon that her children seemed to have recovered from their colds and she said they did, but she had bronchitis. I asked her if she had seen a doctor and she said yes, but she needed her medicaid card to fill the prescription he gave her. She said that her caseworker was supposed to come over and that she wanted the caseworker to get her a medicaid card. I said that I would speak to the worker later and I would tell her this.

2) I asked her how things are going, and she said fine. She obviously was not interested in speaking to me about anything today. When I realized this I began to speak to her children. I asked her if she had some sort of schedule for feeding the children, and she sort of laughed it off and said no. I said that I didn't mean an exact schedule, but some time during the day that the kids expect to be fed. She told me she feeds them breakfast about 9, lunch about 12 and dinner. I said "so you do have some kind of schedule." I mentioned that this was good because little children enjoy having a routine, a time when they can expect something to happen.

3) I asked Sharon if Joseph could count, and she said he used to be able to but when he went back to live with Marie for a while she didn't encourage him to count and he stopped. I asked Joseph if he knew how to count and he said no. I asked him why and he said that he was too dumb. This comment surprised me as I never expected a 4-year-old to be so aware of his feelings. I expect that he not only had no positive reinforcement, but that he had negative reinforcement, while trying to count. It is relevant here that Sharon seemed to have nicknamed both her children, especially when she refers to Joseph, as "dummy." Here is where he might have picked up the term. I said to Joseph "you're not dumb Joseph, you're smart, and you can count if you want to." I had him repeat the numbers one to ten after me, and after each try asked him to try to count by himself. He never could remember to start at one, and always did it all wrong. I went over this with him several times. After it was apparent that he was not really trying to learn the numbers, I stopped, reminding him that he was a very smart boy and would be able to count if he practiced. I asked him if he wanted his mother to practice with him, and he said yes. I said that he should ask his mother to help him with numbers when he wanted to practice them. (Sharon is listening to everything I said.) Sharon said that he is very insecure about learning them, and she and Mike sat one night for hours going over them with Joseph. She said it was very frustrating for Mr. Smith as he wants his son to be real smart. I asked her if Joseph had any number games to play with and she said Santa's bringing them. I played the same game with the alphabet having Joseph repeat them after me. His pronunciation of the letters was very good, and I think it would be a good way to help him improve his speech problem. When we got up to "U" he said "no" and each time I repeated the letter "U" he did the same thing. Sharon said she thought this was very smart of him, she knew he had been doing this and reinforced it.

4) Although it may be a little presumptious on my part, I got the impression that as long as Joseph displays behavior that Sharon considers novel, she will reinforce him -- as long as he's cute and precocious she will love him. Joseph needs his mother's love, and will therefore repeat this behavior as long as Sharon is pleased by it. It also might have other implications, such as a preoccupation with himself and his needs, indicating that they are not being met by his parents. This is only a guess at best, but could be a hint about what Joseph is feeling. Joseph was not able to repeat the alphabet on his own at all. I asked Sharon if he had any alphabet games and she said Santa is bringing one also.

5) Joseph went over to his mother during the interview and crawled up her chair. Sharon told him to get down in a punitive voice, and said that he could climb on his grandfather's furniture but not on hers. Joseph expressed a hurt look at his mother, and she repeated what she said again. He then said "mom--ee" in a pleading voice, as he had done on another occasion when she had teased him. I felt the urge to both tell Sharon what an insensitive, stupid thing she did and to pick up Joseph in my arms and comfort him. I did neither. I felt that Joseph has to live with his mother, not me, and antagonism toward her should not be supported, as there probably is enough to begin with.

He sat down to watch TV, wiping his eyes and trying to hold in his tears. After a few minutes I asked him to come over, placed him on my lap, and this is when we began counting. Later on, Joe showed me his rocking horse. Any interaction I had with Sharon was minimal, but she did watch Joseph and me as we counted and recited the alphabet together. I told Sharon I would see her in four weeks from today, as I was going on my vacation. She said O.K., and both children kissed me good-bye and I left.

6) I felt a little disappointed about the interview, in that Sharon was so open with me the week before, and completely closed up this week. This could have been because the kids were up and she is very aware of why both I and her caseworker are visiting her -- because of the kids. In the next interview, I would like for Sharon to become aware of the fact that she is the focus of my interest, and that in helping her keep her children I am working for her towards her goals (if these are in fact, her goals). So far, I've either concentrated the interview on her problems, or solely focused my attention on the children. Sharon might be confused as to whom I'm trying to help. She might imitate the games I play with Joseph, but then again, she might resent them and see me as a threat -- someone who is teaching her son what she is not, or can not. I want to try to establish more of a relationship with Sharon and have her trust me enough to realize that I want her to play the role with Joseph that I am playing in the hour we are together.

The situation is classic. The worker is poised to learn and articulates her goals to help Sharon. Her recording pinpoints her uncertainty about her role and the self-consciousness which might be impeding any flow of spontaneous comparison for Sharon. Her learning needs are clear and a supervisory process directed toward removing these impediments would have ramifications beyond her work with just this one situation.

As evidenced by the examples cited, supervision is challenging and never lacks situational drama. The variety, complexity, and growth potential for all concerned harbor many satisfactions and opportunities for continual sharpening of skills. Knowledge about human beings and the way they learn, coupled with practice theory, gives the supervisor invaluable tools for service to workers and, ultimately, to clients and community.

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